HIGHMARK

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

☐ ENROLLING
(Complete sections I, II, IV, and V)

☐ WAIVING
(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll Location
2/10/24	County Chemicals Inc.	406002	Dauphin

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
Morrisdale	I	KESHA	612024660 5

Address: Hershey Apts. Flat 173, WAbhegh Ave.

City	State	Zip	County	Home/Cell Phone
Crawford	PA.	16418	LUZURNE	569. 658 - 5816

Marital Status (Please check one):
☐ Single/Widowed ☐ Married
☑ Divorced

Enrollment Status
☒ Active Employee ☐ COBRA Continuant Start Date / /
☐ Retired Employee ☐ HIPAA Life Event
(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)

Full-Time Hire (or Rehire) Date (Month/Day/Year)	Hours Worked Per Week	Job Title
~~9/5/23~~ 10/25/2023	50	OFFICE MANAGER

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☑ Male ☐ Female	07 / 03 / 1970	53	☑ Medical Product Name: SILVER DOMD $3000 Plack ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
JAMIE Clearfield Centre	1291003	☑ Yes ☐ No

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
Daneoys	S	Targoyon	☒ Spouse ☐ Domestic Partner*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
181-76-1847	☐ Male ☒ Female	12 / 16 / 1989	35

Product Selection(s):
☑ Medical ☑ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
XPert Labs	08061995	☑ Yes ☐ No

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

*If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You?
Bradley	W	Snowman	☐ Child ☐ Step-child ☐ Adopted* ☑ Other**

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
886716254 9	☑ Male ☐ Female	03 / 23 / 2017	7

Product Selection(s):
☑ Medical ☑ Vision ☒ Dental

Dependent Status if Age 26 or Older
☐ Disabled ☐ Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		☐ Yes ☐ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.