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

Effective Date: 1/08/2024 | Employer/Group Name: Heart Foundation Inc. | Group Number: 44168015 | Payroll Location: Dauphin

First Name: Samairra ~~[illegible]~~ | MI: H | Last Name: D'Souza | Social Security Number (If no SS#, write N/A): 815-66-1302

Address: 135 Hershey Apts; Bigben Square

City: Pittsburgh | State: PA | Zip: 18506 | County: Erie | Home/Cell Phone: 899-891-8626

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

Enrollment Status: ☒ Active Employee ☐ Rehired Employee ☐ COBRA Continuant Start Date ☐ 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): 11/11/2018 | Hours Worked Per Week: 42+ | Job Title: HealthCare Analyst

Gender: ☐ Male ☒ Female | Date of Birth (Month/Day/Year): 12/31/77 | Age: 46 | Product Selection(s): ☒ Medical Product Name: Platinum+ $10,000 ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice: DR. MUNHALL PERCY | POR Number from Provider Directory: 001189 | Are you an Established Patient? ☐ Yes ☒ No

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

SPOUSE/DOMESTIC PARTNER

First Name: Franklin | MI: Lo | Last Name: D'Souza | Relationship to You? ☒ Spouse ☐ Domestic Partner†

Social Security Number (If no SS#, write N/A): 803-19-9728 | Gender: ☒ Male ☐ Female | Date of Birth (Month/Day/Year): 04/14/1976 ~~2024~~ | Age: 47

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

Full Name of Physician of Record (POR) Group Practice: Dr. Lamina Nanci | POR Number from Provider Directory: 113203 | Is Spouse/DP an Established Patient? ☒ 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? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A) | Gender: ☐ Male ☐ Female | Date of Birth (Month/Day/Year) | Age

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.