

Check, then double-check.

We receive many enrollment and change forms that cannot be processed due to omissions and errors.

When that happens we have to send the form back to you to be corrected. Meanwhile, whether you are new to Priority Health or an existing member, your doctor, pharmacist or hospital won't be able to find you in our system until we have enrolled you.

So, here's what you can do to speed up your enrollment:

1. Fill out the employee section of the form completely.
2. Check everything, then double-check the entries we have circled. They are the ones most often overlooked.
3. Ask your employer or **PriorityHealth** for help if you have questions filling out the form.
4. Give the completed form to your employer to fill out the employer section.

Product Information
HMO, POS, etc.

Option (if applicable)

Employee Signature

Documentation
Supporting loss of coverage.
It must accompany this form.

Enrollment Form
Priority Health • PO Box 205 • Grand Rapids, MI 49501-0205

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name: _____ First Name: _____ Middle Initial: _____ Social Security Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () - / - / Work Phone: () - / - / Gender: Male Female Birth Date: / / E-mail Address: _____

Marital Status: Single Married Separated Divorced Widowed Employee's Priority Health Primary Care Provider (PCP) (REQUIRED for HMO & POS): _____

Have you seen this provider? Yes No PCP Address/ID Code: _____

PRODUCT: HMO POS PPO HBC HRA HSA Other _____

OPTION (if Applicable): High Mid Low

Please list spouse and/or dependents who will be covered under this policy. If you have more than 4 dependents please complete an additional Enrollment Form.

SECTION 2 - COORDINATION OF BENEFITS

If you, your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT? Company Name: _____ Company Address: _____

POLICYHOLDER INFORMATION: Name of Policyholder: _____ Birthdate: / / Policy Effective Date: / / Employer: _____

Family Member(s) Covered: (1) _____ (2) _____ (3) _____ (4) _____

REASON FOR MEDICARE: End Stage Renal Disease Disabled Over Age 65 Over Age 65 and Working Medicare Effective Date: / /

SECTION 3 - AUTHORIZATION

I apply for coverage for each person listed above and agree that we will abide by the Certificate of Coverage and/or Summary Plan Description that applies to our coverage. I understand the Priority Health cannot process my Enrollment Form on time unless I fill in all the information above, in particular, list a PCP for my enrolled dependents and myself. All of the information I have given above is complete and correct. If the Group Plan requires that I make contributions, I authorize my employer to deduct them from my pay.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

Employee Signature: X _____ Date: _____

For Employer Use Only

Employer Representative Signature: _____ Work Location of Employee: _____ Date: / /

Group Number: _____ Sub Group Number: _____ Class: _____ Date of Hire: / / Effective Date: / /

TYPE: Union Non-Union Salary Hourly Cobra RETIREE: Early Retiree (Under 65) Retiree (65+)

PLEASE CHECK ALL APPLICABLE BOXES: LONG TERM DISABILITY: Date of Disability: / /

REASON: New Hire New Group Open Enrollment Loss of Other Coverage Reason: _____

COBRA CONTINUATION: 18 Month 29 Month 36 Month Continuation Code: / / Effective Date: / /

For Priority Health Use Only: Date Received: _____ Processor: _____ Code: _____ Date Processed: _____

Questions?

Members, call Customer Service: 800 446-5674

Thank you for choosing Priority Health as your health insurance.

Enrollment Form



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SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name		First Name		Middle Initial	Social Security Number - -	
Street Address			City		State	Zip Code
Home Phone () -	Work Phone () -	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /	E-mail Address		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Employee's Priority Health Primary Care Provider (PCP) (REQUIRED for HMO & POS)				
Have you seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code				
PRODUCT <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> HBC <input type="checkbox"/> HRA <input type="checkbox"/> HSA			OPTION (If Applicable) <input type="checkbox"/> High <input type="checkbox"/> Mid <input type="checkbox"/> Low			

Please list spouse and/or dependents who will be covered under this policy (if you have more than 4 dependents please complete an additional Enrollment Form).

1	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	
2	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	
3	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	
4	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	

SECTION 2 - COORDINATION OF BENEFITS

If you, your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name		Company Address			
POLICYHOLDER INFORMATION	Name of Policyholder		Birthdate / /	Policy Effective Date / /	Employer	
	Family Member(s) Covered (1) (2) (3) (4)					
REASON FOR MEDICARE	<input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled <input type="checkbox"/> Over Age 65 <input type="checkbox"/> Over Age 65 and Working					Medicare Effective Date / /

SECTION 3 - AUTHORIZATION

I apply for coverage for each person listed above and agree that we will abide by the Certificate of Coverage and/or Summary Plan Description that applies to our coverage. I understand the Priority Health cannot process my Enrollment Form on time unless I fill in all the information above, in particular, list a PCP for my enrolled dependents and myself. All of the information I have given above is complete and correct. If the Group Plan requires that I make contributions, I authorize my employer to deduct them from my pay.

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Employee Signature X _____ Date: _____

For Employer Use Only	Employer			Work Location of Employee		
	Employer Representative Signature				Date / /	
	Group Number		Sub Group Number	Class	Date of Hire / /	Effective Date / /
	PLEASE CHECK ALL APPLICABLE BOXES:	TYPE <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Cobra			RETIREE <input type="checkbox"/> Early Retiree (Under 65) <input type="checkbox"/> Retiree (65+)	
		LONG TERM DISABILITY <input type="checkbox"/> Date of Disability / /				
REASON <input type="checkbox"/> New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Other Coverage Reason: _____						
COBRA CONTINUATION <input type="checkbox"/> 18 Month <input type="checkbox"/> 29 Month <input type="checkbox"/> 36 Month			Qualifying Event Date / /		Effective Date / /	
For Priority Health Use Only	Date Received	Processor		Code	Date Processed	