

Employees

Thank you for choosing Priority Health. Please complete this form for yourself and any dependents you wish to cover. A few reminders to help you complete this form:

- Please print clearly using blue or black ink.
- ALL sections of this form must be completed in order to process coverage for you and your family. If it is not complete and accurate, the form will be sent back to your employer, and this will cause a delay in processing coverage for you and your family.
- If you have any questions or need assistance while completing this form, please call us at 800.446.5674 or 616.942.1221.

Employee information	This information is about the person who will be carrying the insurance.
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This information must be completed if you would like coverage for your spouse and family members.

Dependent information

Please list spouse and/or family members who will be covered under this policy. If you have more than 5, please complete an additional enrollment form.

Note: Please indicate if a dependent lives outside of the Priority Health Michigan service area to ensure appropriate coverage. Go to priorityhealth.com and search for “service area” to see a map or call us for more information.

Authorization	Your signature is needed to let us know that you will abide by an insurance policy, a Certificate of Coverage, an Explanation of Coverage, or the Summary Plan Description that applies to your coverage.
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Social Security number is required to comply with federal reporting requirements.

The completion of race/ethnicity information is optional. The information will be protected and will not affect your access to health care services, benefits, eligibility or premiums. This information will help Priority Health to monitor and improve the quality of care for members.

The term “Priority Health” refers to three corporations: “Priority Health,” “Priority Health Managed Benefits, Inc.” and “Priority Health Insurance Company.” Priority Health is a registered trademark and is used by permission of the owner.

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history, or any requests for or receipt of genetic services.

Enrollment form



All information must be completed to process form.
 Incomplete forms will be returned and not processed.

Employee information				
Employee last name		First name		Middle initial
Street address		City		State
Phone ()	Work phone ()	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth date (month/day/year) / /
Email address		Race/ethnicity (optional) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Primary Care Provider (doctor) last name		Doctor first name		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Doctor street address		City		State
				ZIP code

Authorization

Your signature is needed to let us know that you will abide by an insurance policy, a Certificate of Coverage, an Explanation of Coverage, or a Summary Plan Description that applies to your coverage.

Employee signature X _____	Today's date / /
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To be completed by employer (form cannot be processed without this information)

Original date of hire	For re-hire employee – Date of re-hire / /	Eligibility date / /	Effective date / /
Group number	Subgroup number		Class
Company name		SHOP ID (if plan purchased on SHOP)	
Company phone ()	Email address		
Please check all applicable boxes	Type <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly		Retiree <input type="checkbox"/> Early retiree (under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/> Surviving spouse
	Reason <input type="checkbox"/> New hire <input type="checkbox"/> Open enrollment <input type="checkbox"/> QMCSO (proof required) <input type="checkbox"/> Change of employment status <input type="checkbox"/> New group <input type="checkbox"/> Re-hire <input type="checkbox"/> Move into service area <input type="checkbox"/> Loss of coverage (proof required) <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____		
	COBRA continuation <input type="checkbox"/> 18 months <input type="checkbox"/> 29 months (proof required) <input type="checkbox"/> 36 months <input type="checkbox"/> Qualifying event date: _____ <input type="checkbox"/> COBRA effective date: _____		
Coverage (if applicable)	Health <input type="checkbox"/> HMO open access <input type="checkbox"/> EPO <input type="checkbox"/> POS open access <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity		PPO network
	Health option (if applicable) <input type="checkbox"/> High <input type="checkbox"/> Mid <input type="checkbox"/> Low		Consumer engaged health plan <input type="checkbox"/> HBCA <input type="checkbox"/> HBCR <input type="checkbox"/> HBCI <input type="checkbox"/> HSA <input type="checkbox"/> HSCM
	Dental <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Family		Vision <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Family
Employer signature X _____			Today's date / /

Dependent information (Your spouse, domestic partner and eligible children you wish to enroll)

1 <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other: _____ <i>If applicable</i> <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dependent last name	First name	Middle initial	Social Security number - -	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (month/day/year) / /	Email address		
	Dependent street address				
	City	State	ZIP code	Is this address outside of the Priority Health service area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary Care Provider (doctor) last name		Doctor first name	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Doctor street address		City	State	ZIP code
2 <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other: _____ <i>If applicable</i> <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dependent last name	First name	Middle initial	Social Security number - -	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*		
	Dependent street address				
	City	State	ZIP code	Is this address outside of the Priority Health service area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary Care Provider (doctor) last name		Doctor first name	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Doctor street address		City	State	ZIP code
3 <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other: _____ <i>If applicable</i> <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dependent last name	First name	Middle initial	Social Security number - -	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*		
	Dependent street address				
	City	State	ZIP code	Is this address outside of the Priority Health service area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary Care Provider (doctor) last name		Doctor first name	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Doctor street address		City	State	ZIP code
4 <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other: _____ <i>If applicable</i> <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dependent last name	First name	Middle initial	Social Security number - -	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*		
	Dependent street address				
	City	State	ZIP code	Is this address outside of the Priority Health service area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary Care Provider (doctor) last name		Doctor first name	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Doctor street address		City	State	ZIP code
5 <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other: _____ <i>If applicable</i> <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dependent last name	First name	Middle initial	Social Security number - -	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*		
	Dependent street address				
	City	State	ZIP code	Is this address outside of the Priority Health service area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary Care Provider (doctor) last name		Doctor first name	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Doctor street address		City	State	ZIP code

*optional

Employers

Thank you for choosing Priority Health for your employees. To help us process enrollment forms in a timely manner, follow these simple tips:

- Please print clearly using blue or black ink.
- If you have any questions or need assistance while completing this form, please call us at 616.464.8550 or 866.464.5257.
- Remember to sign the form. We cannot enroll your employee and family members without your signature.

Group number	List your Priority Health group number to ensure proper benefits and billing.
Subgroup number	If your group has more than one subgroup, please list the appropriate subgroup number (S001, S002, etc.).
Class	List the appropriate class to indicate active, retired or specific group location (CA01, CA02, CC01, RE01, etc.).
Your company name, email and contact phone number	Complete your company name, phone number and email address.
Date of hire	For new groups, new hires and open enrollments.
Effective date	Indicate the requested effective date of coverage (the effective date of coverage is subject to your Group Agreement language).
Enrollment section	Remember to check applicable boxes for Type, Retiree and Reason. Remember to check applicable boxes for Coverage (Health, PPO Network, Dental, Vision, CEH, Health Option and Life).
Company representative signature	Your signature is needed to verify the employee's eligibility for coverage.