My**Priority** special enrollment (SEP) form

For coverage beginning in 2024

Priority Health

ENROLLMENT INSTRUCTIONS

Please ensure that all questions are completed and answered with full details provided for the following:

- ☐ Eligibility questions (Step 1)
- ☐ Primary applicant and dependent information (Step 3 and Step 4)
- ☐ Primary doctor (Step 3 and Step 4)
- ☐ Payment information (Step 5)
- ☐ Signatures provided (Step 1, Step 5 and Step 6)
- ☐ Include documentation of qualifying life event (Step 1a, Step 8)

GENERAL INFORMATION

- If you have a qualifying life event, you are eligible under the special enrollment period.
- This means you can enroll in a MyPriority plan outside the open enrollment period. Your special enrollment period lasts 60 days from the date of the qualifying life event (see page 10 for more information).
- The open enrollment period for 2024 MyPriority coverage ended Jan. 16, 2024.

NEED HELP?

If you have questions, please contact your agent or call our enrollment specialists toll-free at 833.709.2957.
We're available Monday–Friday, 8 a.m. to 5 p.m.

STEP 1 ELIGIBILITY

Eligibility requirements for you, your spouse and your dependents.

✔ Qualifying life event

In order to buy a MyPriority health plan outside the open enrollment period, you must have a qualifying life event. Qualifying life events that create a special enrollment period are:

- Getting married
- Having, adopting, or placement of a child
- Change in citizenship
- Permanently moving to a new area that offers different health plan options
- Losing other health coverage (for example due to a job loss, divorce, death of previous policy holder, loss of eligibility for Medicaid or CHIP, expiration of COBRA coverage, or a health plan being decertified). **Note:** Voluntarily quitting other health coverage or being terminated for not paying your premiums are not considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage. You **MUST provide written proof** of loss of other health coverage. Please include the notice from the previous health coverage carrier that includes the policy termination date when you mail your application.
- For people already enrolled in a Qualified Health Plan through *healthcare.gov,* having a change in income or household status that affects eligibility for tax credits or cost-sharing reductions.

✔ Primary contact person

You may enroll as the primary contact person (also called the subscriber or primary applicant) if you are:

- A United States citizen or national and a current resident of Michigan on the effective date of this coverage. To be a resident of Michigan you must intend to live at your address in Michigan longer than six consecutive months prior to your enrollment submission date.
- Age 21 or older.
- Not enrolled in Medicare.
- Not enrolled in any employer-sponsored health plan or other individual health coverage on the date this coverage takes effect.
- Not in detention or incarcerated in a facility such as a jail, prison or youth home. You are also not in the custody of any law enforcement officer or on release for the sole purpose of receiving medical treatment.
- The adult with the earliest birthday in the year, if enrolling with your spouse.

STEP 1 ELIGIBILITY (CONTINUED)

✔ Eligible dependents

You may enroll your spouse and/or eligible dependents if the following statements are true:

- The primary contact person (subscriber/primary applicant) and the spouse are legally married and the spouse is a Michigan resident.
- The dependent(s) is not enrolled in Medicare.
- The dependent children including step children, legally adopted children, natural birth children or legal guardianship children are under the age of 26 the date coverage takes effect.
- The dependent children are incapacitated, and the incapacitation began before their 26th birthday. The dependent is not married if over age 26.
- Spouse and/or dependent(s) are not enrolled in an employer-sponsored health plan or other individual health coverage on the date coverage takes effect.
- Spouse and/or dependent(s) are not in detention or incarcerated in a facility such as a jail, prison or youth home. Spouse and/or dependent children are also not in the custody of any law enforcement officer or on release for the sole purpose of receiving medical treatment.

STEP 1 ELIGIBILITY (CONTINUED)

Eligibility questions

Please read the following statements carefully and check the box for the statement that applies to you. If we later determine that this information is incorrect, your enrollment may be terminated.

1. Are you, the primary applicant, a United States citizen or national, and a current resident of Michigan on the effective date of this coverage? To be a resident of Michigan you must intend to live at your address in Michigan longer than six consecutive months prior to your enrollment submission date.

   ☐ If **yes**, continue to question 2.

   ☐ If **no**, you are not eligible to enroll in MyPriority health plans. You must complete your enrollment in a MyPriority plan at healthcare.gov.

2. Are you, or is anyone enrolling, enrolled in Medicare?

   ☐ If **yes**, anyone enrolled in Medicare is not eligible for MyPriority health plans. Visit priorityhealth.com for information about Medicare plans or call 866.863.1984.

   ☐ If **no**, continue to question 3.

3. Will you, or anyone enrolling, be actively enrolled in a group or association health plan or other individual health coverage on the effective date of this coverage?

   ☐ If **yes**, anyone that will be actively enrolled in another health plan is not eligible to enroll in a MyPriority health plan.

   ☐ If **no**, continue to question 4.

4. Are you, or any family members enrolling in this coverage, incarcerated in a facility such as a jail, prison or youth home?

   ☐ If **yes**, any person incarcerated is not eligible to enroll in health plans.

   ☐ If **no**, continue to question 5.

5. Are any of your dependent children enrolling deemed incapacitated (definition according to Michigan law)?

   ☐ If **yes**, dependents over age 26 are eligible to enroll.

   ☐ If **no**, only dependents under the age of 25 on the effective date are eligible to enroll.

Individuals who are not purchasing coverage on the Health Insurance Marketplace must purchase pediatric dental benefits as part of Essential Health Benefits under health care reform. Even if you don't have children under the age of 19, you are required to purchase pediatric dental.

☐ **Yes**, I declare I have already purchased pediatric dental coverage through a certified stand-alone dental carrier.

☐ **No**, I do not currently have pediatric dental coverage, but understand this is a requirement and certify my intent to purchase this coverage.

I declare the answers to the above questions are true for all enrollees to the best of my knowledge and belief and would be able to provide supporting documentation upon request.

Primary applicant signature _____ Date _____

STEP 1a Select qualifying life event(s) that makes you eligible to enroll during a 60-day special enrollment period.

Please select qualifying life event(s) below that make you eligible to enroll during a 60-day special enrollment period.

Make sure to include the date the qualifying life event occurred.

Qualifying life event	Date it occurred
☐ Loss of minimum essential coverage (Please provide notice from the previous health coverage carrier that includes the policy termination date with application)	
☐ Loss of COBRA benefits	
☐ Marriage	
☐ Birth	
☐ Permanent relocation	
☐ Divorce	
☐ Previous policy holder died	
☐ Adoption	
☐ Named legal guardian for a dependent	
☐ Gained a new foster child	
☐ Change in citizenship	
☐ Newly eligible for government assistance	

STEP 2 SELECT THE HEALTH PLAN YOU WOULD LIKE TO ENROLL IN

MyPriority HMO plans:

- ☐ My**Priority** Value Bronze
- ☐ My**Priority** Value Bronze Corewell Health West Michigan Network*
- ☐ My**Priority** Value Bronze Bronson Healthcare Partners*
- ☐ My**Priority** Value Bronze Southeast Michigan Network*
- ☐ My**Priority** Value Bronze Trinity Health East Network*

- ☐ My**Priority** Balanced Silver Off Marketplace
- ☐ My**Priority** Balanced Silver Off Marketplace Corewell Health West Michigan Network*
- ☐ My**Priority** Balanced Silver Off Marketplace Bronson Healthcare Partners*
- ☐ My**Priority** Balanced Silver Off Marketplace Southeast Michigan Network*
- ☐ My**Priority** Balanced Silver Off Marketplace Trinity Health East Network*

- ☐ My**Priority** Balanced Silver
- ☐ My**Priority** Balanced Silver Corewell Health West Michigan Network*
- ☐ My**Priority** Balanced Silver Bronson Healthcare Partners*
- ☐ My**Priority** Balanced Silver Southeast Michigan Network*
- ☐ My**Priority** Balanced Silver Trinity Health East Network*

- ☐ My**Priority** Premier Silver Off Marketplace
- ☐ My**Priority** Premier Silver Off Marketplace Corewell Health West Michigan Network*
- ☐ My**Priority** Premier Silver Off Marketplace Bronson Healthcare Partners*
- ☐ My**Priority** Premier Silver Off Marketplace Southeast Michigan Network*
- ☐ My**Priority** Premier Silver Off Marketplace Trinity Health East Network*

- ☐ My**Priority** Premier Silver
- ☐ My**Priority** Premier Silver Corewell Health West Michigan Network*
- ☐ My**Priority** Premier Silver Bronson Healthcare Partners*
- ☐ My**Priority** Premier Silver Southeast Michigan Network*
- ☐ My**Priority** Premier Silver Trinity Health East Network*

- ☐ My**Priority** Enhanced Gold Corewell Health West Michigan Network*
- ☐ My**Priority** Enhanced Gold Bronson Healthcare Partners*
- ☐ My**Priority** Enhanced Gold Southeast Michigan Network*
- ☐ My**Priority** Enhanced Gold Trinity Health East Network*

Visit *mypriority.com* for information on all MyPriority plans.

STEP 2 SELECT THE HEALTH PLAN YOU WOULD LIKE TO ENROLL IN (CONTINUED)

MyPriority HSA plans:

- ☐ My**Priority** Value Bronze HSA
- ☐ My**Priority** Value Bronze HSA Corewell Health West Michigan Network*
- ☐ My**Priority** Value Bronze HSA Bronson Healthcare Partners*
- ☐ My**Priority** Value Bronze HSA Southeast Michigan Network*
- ☐ My**Priority** Value Bronze HSA Trinity Health East Network*

- ☐ My**Priority** Prime Silver HSA Off Marketplace
- ☐ My**Priority** Prime Silver HSA Off Marketplace Corewell Health West Michigan Network*
- ☐ My**Priority** Prime Silver HSA Off Marketplace Bronson Healthcare Partners*
- ☐ My**Priority** Prime Silver HSA Off Marketplace Southeast Michigan Network*
- ☐ My**Priority** Prime Silver HSA Off Marketplace Trinity Health East Network*

MyPriority Standard plans:

- ☐ My**Priority** Standard Bronze
- ☐ My**Priority** Standard Bronze Corewell Health West Michigan Network*
- ☐ My**Priority** Standard Bronze Bronson Healthcare Partners*
- ☐ My**Priority** Standard Bronze Southeast Michigan Network*
- ☐ My**Priority** Standard Bronze Trinity Health East Network*
- ☐ My**Priority** Standard Bronze Travel

- ☐ My**Priority** Standard Silver
- ☐ My**Priority** Standard Silver Corewell Health West Michigan Network*
- ☐ My**Priority** Standard Silver Bronson Healthcare Partners*
- ☐ My**Priority** Standard Silver Southeast Michigan Network*
- ☐ My**Priority** Standard Silver Trinity Health East Network*
- ☐ My**Priority** Standard Silver Travel

- ☐ My**Priority** Standard Gold
- ☐ My**Priority** Standard Gold Corewell Health West Michigan Network*
- ☐ My**Priority** Standard Gold Bronson Healthcare Partners*
- ☐ My**Priority** Standard Gold Southeast Michigan Network*
- ☐ My**Priority** Standard Gold Trinity Health East Network*
- ☐ My**Priority** Standard Gold Travel

Add MyPriority dental coverage:

- ☐ My**Priority** Delta Dental – Standard
- ☐ My**Priority** Delta Dental – Enhanced

MyPriority vision coverage:

- ☐ My**Priority** EyeMed – Medium
- ☐ My**Priority** EyeMed – High

Visit *mypriority.com* for information on all MyPriority plans.

**Corewell Health West Michigan Network is a narrow network plan available only to residents who live in Kent, Barry, Mecosta, Newaygo, Ottawa counties and a portion of Allegan County. ZIP Codes in Allegan County where this narrow network is offered: 49070, 49311, 49314, 49323, 49328, 49335, 49344, 49348, 49406, 49408, 49416, 49419, 49423, 49453. Corewell Health West Michigan Network does not include Corewell Health hospitals in Southwest or Southeast Michigan.*
**Bronson Healthcare Partners is a narrow network plan available only to residents who live in Kalamazoo, Van Buren and a portion of Calhoun counties.*
ZIP codes in Calhoun County where this narrow network is offered: 49011, 49014, 49015, 49017, 49021, 49029, 49033, 49037, 49051, 49052, 49068, 49076, 49092, 49094
**Southeast Michigan Network is a narrow network plan available only to residents who live in Macomb, Oakland and Wayne counties.*
**Trinity Health East Network is a narrow network plan available only to residents who live in Livingston, Washtenaw counties and a portion of Jackson County. Zip codes in Jackson County where this narrow network is offered: 49201, 49202, 49203, 49204, 49230, 49240, 49254, 49259, 49261, 49263, 49272, 49277, 49285*

STEP 3 PRIMARY APPLICANT INFORMATION

You must provide information in every section in order for us to process your enrollment form.

Last name	First name	Middle initial	Social Security number - -
Street address			
City	County	State	ZIP code
Phone number that we may use to contact you: ( ) ☐ Landline (home phone) ☐ Cell phone		Alternate number that we may use to contact you (optional): ( ) ☐ Landline (home phone) ☐ Cell phone	
Gender ☐ Male ☐ Female	Birth date (month/date/year) / /	Age	Country of origin
Email address			
Primary doctor	Tobacco use: ☐ Yes ☐ No Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).		

STEP 4 SPOUSE AND DEPENDENT INFORMATION

Please add information for eligible family members.
If you have more than three (3) dependents complete an additional form and include it with this form.

1

Spouse last name	First name	Middle initial	Gender ☐ Male ☐ Female	
Social Security number - -	Birth date (month/day/year) / /	Age	Country of origin	☐ Dental Coverage ☐ Vision Coverage
Primary doctor	Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 and over) Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).			

2

Dependent last name	First name	Middle initial	Gender ☐ Male ☐ Female	
Social Security number - -	Birth date (month/day/year) / /	Age	Country of origin	☐ Dental Coverage ☐ Vision Coverage
Primary doctor	Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 and over) Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).			

3

Dependent last name	First name	Middle initial	Gender ☐ Male ☐ Female	
Social Security number - -	Birth date (month/day/year) / /	Age	Country of origin	☐ Dental Coverage ☐ Vision Coverage
Primary doctor	Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 and over) Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).			

4

Dependent last name	First name	Middle initial	Gender ☐ Male ☐ Female	
Social Security number - -	Birth date (month/day/year) / /	Age	Country of origin	☐ Dental Coverage ☐ Vision Coverage
Primary doctor	Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 and over) Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).			

STEP 5 PAYMENT INFORMATION

1. Choose how often you pay:

- ☐ Monthly
- ☐ Quarterly (Equal to three months premium)
- ☐ Semi-annually (Equal to six months premium)
- ☐ Annually (Equal to 12 months premium)

2. Choose one payment option:

- ☐ Electronic Funds Transfer (EFT)
- ☐ Mail me a bill

When paying by EFT, the initial payment draft will occur within 24 hours after the application is processed. Recurring payments will be drafted on the first business day of the month based on the frequency you selected.

- If your account does not have enough money to pay your premium we will get a "non-sufficient funds" (NSF) notice from your account and we will charge you an extra $25.
- If we don't receive and post your first premium payment within 30 days of the start date of your policy, your policy will terminate as of the original effective date.
- If we don't receive and post all subsequent payments by the last day of the month in which the premium is due, we will terminate your policy as of the last date your policy was paid in full.
- You must notify Priority Health of any changes to your designated account at least five business days before the last day of the month.

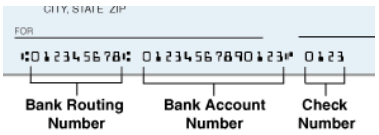
Acceptance of payment terms

If I chose EFT I authorize Priority Health to deduct from the account listed below my first premium payment based on the billing frequency I indicated above. I understand my account will be debited on the first business day of every month in which the payment is due. If at any time I decide to discontinue automatic electronic fund transfer payments, I will notify Priority Health in writing 30 days before discontinuing.

3. If using Electronic Funds Transfer (EFT), please enter your financial institution information below:

Name of financial institution	Account type ☐ Checking ☐ Savings	
ABA / routing number (nine digits on the bottom of check for a checking account)	Account number	
Print name	Account holder's signature	Date

Example:



STEP 6 IMPORTANT AUTHORIZATION AND VERIFICATION INFORMATION

You must provide information in every section in order for us to process your enrollment form.

My signature below indicates that I have read and understand the contents of this enrollment form. I declare that the answers and information presented on this enrollment form are complete and true for all enrollees to the best of my knowledge and belief. I understand that the enrollment form and any amendments become part of the contract and that if any information and answers are incomplete, incorrect or untrue, Priority Health may have the right to rescind (cancel) coverage, adjust premium and/or reduce benefits.

Enrollment is not guaranteed until eligibility is confirmed, and I understand that I should not cancel any current coverage until I receive written notice of approval from Priority Health.

I understand that any person who, knowingly and with intent to defraud any health coverage company or other person, files an enrollment form for coverage or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent health coverage act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.

I understand the coverage under the plan I am enrolling in will not take effect until issued by Priority Health.

Priority Health requires proper handling of personal health information for applicants and members, and details of confidentiality policies and procedures are available to me upon my written request to Priority Health.

I understand that this coverage is not an employer group health plan and is not intended to be an employer-sponsored health plan. I certify that my employer will not contribute any funds toward the cost of this coverage.

I agree that I, along with any dependents, will accept and receive member material online (via *priorityhealth.com*).

Primary applicant (subscriber) signature	Date
Spouse/dependent (if age 18 or older) signature	Date
Dependent (if age 18 or older) signature	Date
Dependent (if age 18 or older) signature	Date
Dependent (if age 18 or older) signature	Date

STEP 7 FOR AGENT

If an agent assisted with the sale or completion of this application, the agent is required to complete the following information:

Agent last name		Agent first name	Agency name
Agent number		Email address	
Primary phone ( )	Fax number ( )	General agency	General agency ID
Agent signature			Date

STEP 8 FINAL STEPS

1. Enrollment form can be mailed or faxed and must be received within 30 days after you sign and date the application.

   Email all forms to: *mypriority@priorityhealth.com*

   Mail all required forms using either the enclosed business reply envelope, or address to:
   Priority Health
   Individual Operations
   1231 East Beltline Ave. NE
   Grand Rapids, MI 49525-4501

   Fax all forms to: 248.324.2973

2. After we receive your enrollment form and your first payment, we'll mail your ID cards and member materials.

Thank you for choosing Priority Health.