Under 21 enrollment form

For coverage beginning in 2024

Priority Health

Thank you for your interest in My**Priority**.® This form is only for primary applicants who are under the age of 21.

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)

General Information

Open Enrollment for 2024 will run from November 1, 2023 through January 15, 2024.

Enrollment between November 1, 2023 and December 15, 2023 will have coverage effective January 1, 2024.

Enrollment between December 16, 2023 and January 15, 2024 will have coverage effective February 1, 2024.

Need help?

If you have questions, please contact your agent or call our enrollment specialists toll-free at **833.532.0390.**

We're available Monday–Friday 8 a.m. to 8 p.m.,

Saturday–Sunday 9 a.m. to 1 p.m.

STEP 1 Eligibility

Eligibility requirements for you, your spouse and your dependents.

A 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.
- Under the age of 21.
- Not eligible for or enrolled in Medicare.
- Not enrolled in any employer health insurance plan or other individual health insurance 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.

B 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 eligible for or 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 health insurance plan or other individual health insurance 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 insurance plans.
     You must complete your enrollment in a MyPriority plan at *healthcare.gov*.

2. Are you, or is anyone enrolling, eligible for or enrolled in Medicare?
   - ☐ If **yes**, anyone eligible for or enrolled in Medicare is not eligible for MyPriority health insurance plans.
     Visit *priorityhealth.com* for information about Medicare plans or call 888.356.1354.
   - ☐ 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 insurance on the effective date of this coverage?
   - ☐ If **yes**, anyone that will be actively enrolled in another health insurance plan is not eligible to enroll in a MyPriority health insurance 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 insurance 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 (if age 18 – 20) signature ______________________ Date ____________

Signature required from responsible party if primary applicant is a minor under the age of 18 ______________________ Date ____________

STEP 2 Enrollment

Select the health plan in which you would like to enroll.

MyPriority HMO plans:

☐ MyPriority Value Bronze
☐ MyPriority Value Bronze Corewell Health West Michigan Network*
☐ MyPriority Value Bronze Bronson Healthcare Partners*
☐ MyPriority Value Bronze Southeast Michigan Network*
☐ MyPriority Value Bronze Trinity Health East Network*

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

☐ MyPriority Balanced Silver
☐ MyPriority Balanced Silver Corewell Health West Michigan Network*
☐ MyPriority Balanced Silver Bronson Healthcare Partners*
☐ MyPriority Balanced Silver Southeast Michigan Network*
☐ MyPriority Balanced Silver Trinity Health East Network*

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

☐ MyPriority Premier Silver
☐ MyPriority Premier Silver Corewell Health West Michigan Network*
☐ MyPriority Premier Silver Bronson Healthcare Partners*
☐ MyPriority Premier Silver Southeast Michigan Network*
☐ MyPriority Premier Silver Trinity Health East Network*

☐ MyPriority Enhanced Gold Corewell Health West Michigan Network*
☐ MyPriority Enhanced Gold Bronson Healthcare Partners*
☐ MyPriority Enhanced Gold Southeast Michigan Network*
☐ MyPriority Enhanced Gold Trinity Health East Network*

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

STEP 2 Enrollment, *continued*

Select the health plan in which you would like to enroll.

MyPriority HSA plans:

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

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

MyPriority Standard Plans:

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

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

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

Add MyPriority dental coverage:

- ☐ MyPriority Delta Dental – Standard
- ☐ MyPriority Delta Dental – Enhanced

Add MyPriority vision coverage:

- ☐ MyPriority EyeMed – Medium
- ☐ MyPriority EyeMed – High

**Narrow network 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*

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
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).			☐ Vision Coverage

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
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).			☐ Vision Coverage

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
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).			☐ Vision Coverage

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
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).			☐ Vision Coverage

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. We will debit your account listed for the amount of your monthly/quarterly/semi-annual/annual premium based on the frequency you selected.

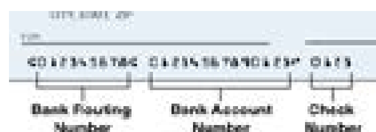
   - If your account does not have enough money to pay your premium we will get a "non-sufficient funds" (NSF) notice from your account and we will charge you an extra $25.
   - If we don't receive and post your first premium payment within 30 days of the start date of your policy, your policy will terminate 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 insurance 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 insurance company or other person, files an enrollment form for insurance 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 insurance 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 insurance 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 (if age 18 - 20) signature	Date
Spouse/dependent (if age 18 or older) signature	Date
Dependent (if age 18 or older) signature	Date
Responsible party name (printed)*	Date
Responsible party signature*	Date

For primary minor applicants under the age of 18, name and signature is required by an adult age 18 or older that will be responsible for paying the health insurance premium.

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.

   Mail all required forms using either the enclosed business reply envelope, or address to:
   Priority Health
   Individual Operations
   27777 Franklin Road, Suite 1300
   Southfield, MI 48034

   Fax all forms to: 248.324.2973 (Attention: MyPriority)

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

2. The initial payment draft will occur within 24 hours after the application is processed.

Thank you for choosing Priority Health.

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).
ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم:711).

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