



☐ BUY UP

ENROLLMENT FORM CORE

Student Information											
Note: If yo	u do not	select a Primar	y Care Phy	ysician, o	ne will a	utomati	cally be assign	ed by Prior	ity Health.		
Student last name		First Nar	First Name			Middle Initial	Social Sec	urity number	Gender		
										☐ Male ☐ Female	
Street Address				1				State	Zip Cod	de	_
Birth Date E-mail address					Home/Cell phone			Marital statu	s Divorced Widowed		
1 1						()			☐ Single ☐ Married		
Primary Care Physician (PCP)			PCP address			S			Are you a current patient?		
									☐ Yes ☐ No		
I am electing			☐ BUY UF								
		(Your spouse a									
NOTE: If yo		t elect a PCP for last name	your fam	nily memi	bers one		Name	assigned by	Middle Initial	Social Security number	
1	ороизе	last flame				1 1131	Ivanic		Wildale IIIItal	Social Security Humber	
	Dirth Do	ato.	Condor		Homo/C	Call phone		I E Ma	ail Addross		
☐ Spouse	Birth Date / /			Gender He ☐ Male ☐ (ome/Cell phone)		E-Mail Address			
			Female		, ,						
	Primary	Care Physician (F	CP)	PCP	address			•		Are you a current patient?	
	Family member last name					Eiret	First Name		Middle Initial	☐ Yes ☐ No ☐ Social Security number	
2	r anny i	nember last flame				Filst	Ivaille		Wildale IIIIllai	Social Security Humber	
☐ Natural/	School or family member's permanent address								Ctoto	Zip Code	
Adopted Child Stepchild	School	or family members	permanen	ermanent address		City		State		Zip Code	
☐ Other	Birth Date		Gender Ho		Home/C	ome/Cell phone		E-Mail Address			
				☐ Male ☐ Female ()					
	Primary Care Physician (Po		CP)	CP) PCP add		Idress				Are you a current patient? ☐ Yes ☐ No	
	Family r	nember last name				First	Name		Middle Initial	Social Security number	
3	,										
☐ Natural/	School	or family member's	nermanen	permanent address		City			State	Zip Code	
Adopted Child Stepchild	00.100.	oayoo	Pomicinon	pormanom address		S.I.y		Clair			
☐ Other						lome/Cell phone		E-Mail Address			
		Care Physician (P	☐ Male ☐		() address					Are you a current patient?	
	Primary Care Physician (PCP) PCP a				auuress					☐ Yes ☐ No	
	Family r	member last name				First	Name		Middle Initial	Social Security number	r
4											
☐ Natural/ Adopted Child	School	or family member's	nt address		Ci	ty		State	Zip Code	_	
Stepchild		<u>-</u>		•							
☐ Other			Gender □ Male □			ome/Cell phone)		E-Mail Address			
		Care Physician (F		`			,			Are you a current patient?	_
	,	- <i>,</i> (,							☐ Yes ☐ No	





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OAKLAND UNIVERSITY WILLIAM BEAUMONT To be completed by OUWB School of Medicine										
Date of enrollment	Effective date of cov	rerage								
Date of officialities	Enocave date of cov	incense date of coverage								
Group Number	Group Name				Group Phone					
787792	edicine			370-2727						
Reason: ☐ New Student ☐ Loss of coverage (s	L submit proof)	Network:								
☐ Open Enrollment ☐ Other	• /	HMO open Access								
		·								
Plan Election:										
☐ Core Plan ☐ Buy Up Plan										
Authorization										
Your signature is needed to let us know that you will abide by the Certificate of Coverage that applies to your coverage.										
Student Signature		Today's Date								
X	 									
OUWB School of Medicine Representati	Today's Date									
X										
For internal use										
Contract Number	Initials			Date						