OU WB School of MEDICINE
OAKLAND UNIVERSITY WILLIAM BEAUMONT

PriorityHealth

ENROLLMENT FORM ☐ **CORE** ☐ **BUY UP**

Student Information

Note: If you do not select a Primary Care Physician, one will automatically be assigned by Priority Health.

Student last name	First Name	Middle Initial	Social Security number	Gender ☐ Male ☐ Female

Street Address	City	State	Zip Code

Birth Date / /	E-mail address	Home/Cell phone ( )	Marital status ☐ Divorced ☐ Widowed ☐ Single ☐ Married

Primary Care Physician (PCP)	PCP address	Are you a current patient? ☐ Yes ☐ No

I am electing: ☐ CORE PLAN ☐ BUY UP PLAN

Family Information (Your spouse and eligible children you wish to enroll).

NOTE: If you do not elect a PCP for your family members one will automatically be assigned by Priority Health.

1 ☐ Spouse

Spouse last name	First Name	Middle Initial	Social Security number

Birth Date / /	Gender ☐ Male ☐ Female	Home/Cell phone ( )	E-Mail Address

Primary Care Physician (PCP)	PCP address	Are you a current patient? ☐ Yes ☐ No

2 ☐ Natural/ Adopted Child ☐ Stepchild ☐ Other

Family member last name	First Name	Middle Initial	Social Security number

School or family member's permanent address	City	State	Zip Code

Birth Date / /	Gender ☐ Male ☐ Female	Home/Cell phone ( )	E-Mail Address

Primary Care Physician (PCP)	PCP address	Are you a current patient? ☐ Yes ☐ No

3 ☐ Natural/ Adopted Child ☐ Stepchild ☐ Other

Family member last name	First Name	Middle Initial	Social Security number

School or family member's permanent address	City	State	Zip Code

Birth Date / /	Gender ☐ Male ☐ Female	Home/Cell phone ( )	E-Mail Address

Primary Care Physician (PCP)	PCP address	Are you a current patient? ☐ Yes ☐ No

4 ☐ Natural/ Adopted Child ☐ Stepchild ☐ Other

Family member last name	First Name	Middle Initial	Social Security number

School or family member's permanent address	City	State	Zip Code

Birth Date / /	Gender ☐ Male ☐ Female	Home/Cell phone ( )	E-Mail Address

Primary Care Physician (PCP)	PCP address	Are you a current patient? ☐ Yes ☐ No

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To be completed by OUWB School of Medicine		
Date of enrollment	Effective date of coverage	
Group Number 787792	Group Name OUWB School of Medicine	Group Phone (248) 370-2727
Reason: ☐ New Student ☐ Loss of coverage (submit proof) ☐ Open Enrollment ☐ Other _____		Network: 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 X_____	Today's Date
OUWB School of Medicine Representative Signature X_____	Today's Date

For internal use		
Contract Number	Initials	Date