



☐ Yes ☐ No

	TY WILLIAM BEAUMONT ENT FORM					☐ CORE H	но		BUY UP HI	МО	☐ BUY UP PPO
Student In	formation										
Student last	First Name	,			Middle Initial	Social Security number				Gender ☐ Male ☐ Female	
Street Addre	ess			City			Sta	ate	Zip Cod	de	
Birth Date E-mail address			Home/Cell pho			phone				us □ Divorced □ Widowed	
1 1			()							e	
If you enroll	in the CORE or BUY UP	HMO plans, you	must sel	ect a PCI	P. If you	do not select	a Prim	ary Ca	•		
assigned by	Priority Health.										
Primary Care Physician (PCP)			PCP address							e you a current patient? Yes	
I am electing	: CORE HMO	☐ BUY UP HM	О ВU	JY UP PP	20				•		
	ormation (Your spouse u do not elect a PCP for Spouse last name		-			lly be assigne	ed by P	riority	Health.		Social Security number
1	Spouse last name				FIRST IN	ame			Middle IIIIIai		Social Security number
	Birth Date	Gender	Н	ome/Cell	l phone			il Address	I		
☐ Spouse	/ /	☐ Male ☐	()							
	Primary Care Physician	Female (PCP)	PCP ad	droce						Δτο	you a current patient?
	Trimary Care r mysician	(1 01)	i Oi au	uress							/es □ No
	Family member last nar	ne			First Na	ame			Middle Initial	{	Social Security number
2	School or family member's permanent address				City				State Zip Code		Zin Code
☐ Natural/	Ochool of family member	o permanent at	idi C33		Oity				Otato	-	Lip Gode
Adopted Child	Birth Date	Gender	H	ome/Cell	l phone		E-Mail Address			,	
☐ Stepchild	1 1	☐ Male ☐ Fen)						•	
☐ Other	Primary Care Physician	(PCP)	PCP ad	dress							you a current patient? ∕es
	Family member last nar	no.			First Na	ame			Middle Initial		Social Security number
3	Tanniy member last har	no .			1 1130140	arric			Wildalo IIIIIai		Social Cooding Hambol
☐ Natural/	School or family member's permanent address				City	City			State	2	Zip Code
Adopted Child	Birth Date	Gender	T H	ome/Cell	l phone			F-Ma	il Address		
☐ Stepchild	1 1	☐ Male ☐ Fen	,)	. роо				/ 144. 555		
☐ Other	Primary Care Physician	(PCP)	PCP ad	dress						Are	you a current patient?
										□ <i>\</i>	∕es □ No
4	Family member last name				First Name				Middle Initial		
4 ☐ Natural/	School or family member's permanent address				City			State		number Zip Code	
☐ Naturai/	•										
☐ Stepchild	Birth Date / /	Gender	,	ome/Cell)	l phone	E-Mail Address			il Address		
☐ Other		☐ Male ☐ Fen		,						Λ	vou a current nation!?
	Primary Care Physician	(FCP)	PCP ad	uress						Are	you a current patient?





To be completed by OUWB School of Medicine										
Date of enrollment	Effective date of co	verage								
Group Number	Number Group Name		Gro	oup Phone						
787792	OUWB School of I		(248	248) 370-2727						
Reason: ☐ New Student ☐ Loss of coverage (s	submit proof)									
☐ Open Enrollment ☐ Other		HMO open Access or PPO								
Plan Election:										
□ Core HMO □ Buy Up HMO □ Buy Up PPO										
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 Representat	Today's Date									
X										
For internal use										
Contract Number	Initials		Date							