Application for Employment

PRIMECARE Medical

3940 Locust Lane
Harrisburg, PA 17109

Consideration is given to applicants for all positions without regard to race, color, religion, gender, national origin, age, marital or veteran status, disability, or any other legally protected status.

(PLEASE PRINT OR TYPE)

Position(s) applied for: _____ Date of Application _____

How did you learn about us?

Advertisement _____ Friend _____ Walk-in _____
Employment Agency _____ Relative _____ Other _____

Last Name First Name Middle Name

Address *Number* *Street* *City* *State* *Zip Code*

Telephone Number _____ _____ ___ - ___ - ____
Daytime *Evening* Social Security Number

Please check "Yes" or "No" or write the appropriate response.	**Yes**	**No**
Can you provide required proof of eligibility to work if you are under 18 years of age?		
Have you ever applied to work with us before? If yes, give date: _____		
Have you ever been employed by us before? If yes, give date: _____		
Are you employed currently?		
If yes to the above, may we contact your present employer?		
Visa or Immigration Status can prevent you from lawfully becoming employed in this country. Can you provide proof of citizenship or immigration status?		
You will be available for work on what date? _____		
Would you prefer: Full Time Part Time Shift Work Temporary?		
Are you presently on "lay-off" status and subject to recall?		
Do you object to travel if a job required it?		
Within the last 7 years, have you been convicted of a felony?		

Conviction will not necessarily disqualify an applicant from employment.

If yes, please give an explanation: _____

_____

_____

_____

AN EQUAL OPPORTUNITY EMPLOYER

Education

	Name and Location	Years Completed	Diploma/Degree	Course of Study
Elementary School		4 5 6 7 8		
High School		9 10 11 12		
Undergraduate College/University		1 2 3 4		
Graduate/Professional		1 2 3 4		

Indicate any specialized training, apprenticeship, skills and extra-curricular activities: _____

Describe honors you have received: _____

Other information you feel may be helpful to us in considering your application: _____

Indicate any foreign language you can speak, read, and/or write

	Speak	Read	Write
Fluent			
Good			
Fair			

Have you ever held any professional, trade, business, or civic positions or offices? Please list:
You may exclude memberships which would reveal sex, race, religion, national origin, age, ancestry, handicap, or other protected status.

References

Name	1.	2.	3.
Address			
Phone			

	Yes	No
Have you ever had any job-related experience in the United States military? If yes, please describe:		
Are you physically or otherwise unable to perform the duties of the position for which you are applying?		

Employment Experience

Begin with present position or last position held. Please include any job-related military assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender, national origin, handicap, or other protected status.

EMPLOYER	DATES EMPLOYED FROM TO	WORK PERFORMED
ADDRESS ______		
TELEPHONE NUMBER(S) ______	HOURLY RATE/SALARY START FINAL	
JOB TITLE SUPERVISOR		
REASON LEAVING		
EMPLOYER	DATES EMPLOYED FROM TO	WORK PERFORMED
ADDRESS ______		
TELEPHONE NUMBER(S) ______	HOURLY RATE/SALARY START FINAL	
JOB TITLE SUPERVISOR		
REASON LEAVING		
EMPLOYER	DATES EMPLOYED FROM TO	WORK PERFORMED
ADDRESS ______		
TELEPHONE NUMBER(S) ______	HOURLY RATE/SALARY START FINAL	
JOB TITLE SUPERVISOR		
REASON LEAVING		
EMPLOYER	DATES EMPLOYED FROM TO	WORK PERFORMED
ADDRESS ______		
TELEPHONE NUMBER(S) ______	HOURLY RATE/SALARY START FINAL	
JOB TITLE SUPERVISOR		
REASON LEAVING		

If additional space is needed, please continue on a separate sheet of paper.

Special Skills and Qualifications

Give a summary of special job-related skills and qualifications acquired from employment or other experience.

Applicant's Statement

To the best of my knowledge, I certify that the answers given here are true and complete.

I agree to authorize any necessary investigation of all statements contained in this application for employment to arrive at an employment decision.

Applications for employment shall be considered active for a 45-day period. If you wish to be considered for employment beyond this time period, you must inquire as to whether or not applications are being accepted at that time.

I, the undersigned, understand and acknowledge that any employment relationship with this organization is of an "at will" nature, unless otherwise defined by applicable law. An Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. Furthermore, this "at will" relationship may not be altered by any written document or by conduct unless such alteration is specifically acknowledged in writing by an authorized executive of this organization.

I also understand that false or misleading information given in this application or interview(s) may result in discharge if employment results from this application. Finally, I understand that I am required to abide by all rules and regulations of the employer.

Signature of Applicant **Date**

X

PRIMECARE MEDICAL, INC.

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

DATE: _____ / _____ / _____

TO: _____
Employer

_____
Address

_____

_____
Employee Signature

_____
Address

_____

_____ / _____ / _____
Date of Employment

_____
Position or Department

SSN: _____ - ____ - _____

THE ABOVE NAMED EMPLOYEE AUTHORIZES:

The release of the below checked employment information to any third party who makes request for same. Those items for which information may be released include: (Please check)

_____ **Salary**

_____ **Position**

_____ **Department**

_____ **Dates of Employment**

_____ **Part-time/Full-time Hours Worked**

_____ **Garnishes or wage attachments or Attachments of another kind**

_____ **Reason for Separation**

_____ **Medical/Accident/Illness Report**

_____ **Other (Please specify)**_____

_____

PLEASE REMIT INFORMATION REQUESTED TO:

Junior Vice President of Human Resources
PrimeCare Medical, Inc.
3940 Locust Lane
Harrisburg, PA 17109-4023

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶**START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line H above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

PRIMECARE MEDICAL, INC.

Employee Direct Deposit Authorization

_____ New Payroll Deposit _____ Change Deposit Information _____ Stop Direct Deposit

Name: _____ SS#: _____

Facility: _____

I hereby authorize my employer, PrimeCare Medical, (hereinafter COMPANY) to deposit any amounts owed me to the following accounts.

SECTION 1 - CHECKING AC COUNT **Please attach a Void Check**

Bank Name: _____ City: _____ State: _____

I wish to Deposit: $_____._____ or ☐ Remaining Net Amount

ATTACH A VOID CHECK HERE

The numbers on the bottom of your voided check are used to make the electronic funds transfer directly to your account.

SECTION 2 - SAVINGS ACCOUNT: **Call your bank to obtain the following information:**

Bank Name: _____ City: _____ State: _____

I wish to Deposit: $_____._____ or ☐ Remaining Net Amount

BANK/ROUTING & TRANSIT # _____ _____ _____ _____ _____ _____ _____ _____ _____
(THIS NUMBER MUST BE NINE [9] DIGITS LONG)

EMPLOYEE SAVINGS ACCOUNT # _____

THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL COMPANY AND BANK HAVE RECEIVED WRITTEN NOTICE FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD COMPANY AND BANK A RESONABLE OPPORTUNITY TO ACT ON IT.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

DCED-CLGS-06 (1-11)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
GOVERNOR'S CENTER FOR LOCAL GOVERMENT SERVICES

LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE

CERTIFICATION

SIGNATURE OF EMPLOYEE	DATE
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

Select Get Local Gov Support, >Municipal Statistics

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at Employment Posting Area for you to view. Also, you may get a copy of this list from The HSA or DON.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. **If you have questions, be sure you have your rights and duties explained to you before signing this form.**

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

PRIMECARE MEDICAL, INC.

Employee Tuberculosis Testing

Employee Name:_____

Employee DOB: _____ Hire Date:_____

Previous Testing: Yes _____ No _____

Past Positive: Date:_____ Location:_____
(Past Positives MUST be verified)

Has the employee experienced any of the following signs / symptoms:

	YES	NO
Chronic Cough	☐	☐
Unexpected Weight Loss	☐	☐
Night Sweats	☐	☐
Hemoptosis	☐	☐
Fatigue	☐	☐

Date PPD Planted	Nurses Initial	Date Read	Nurses Initial	Reaction	CXR Date	Results
1.						
2.						
3.						
4.						
5.						
6.						

MANUFACTURER	LOT NUMBER	DATE SOLUTION USED
1.		
2.		
3.		
4.		
5.		
6.		

PRIMECARE MEDICAL, INC.

HBV VACCINATION CONSENT FORM

I, _____ Consent Do Not Consent

On the _____ day of _____, _____ to the HBV Vaccination provided to me at no
Day Month Year

cost by PrimeCare Medical, Inc.

I further understand that the vaccination will be given in three (3) injections by the PrimeCare Medical Physician or designee as directed by the manufacturer and agree that PrimeCare Medical is acting only as the Administrator of the vaccination and that any ramification whatsoever concerning the vaccination or disease shall be the responsibility of the Manufacturer.

INDICATIONS AND USAGE: Vaccination is recommended for personnel who are or will be at increased risk of infection with Hepatitis B including, nurses, physicians, paramedical personnel, custodial staff, laboratory personnel, etc. This vaccination is effective only for Hepatitis B and no other type of Hepatitis.

CONTRAINDICATIONS: Hypersensitivity to yeast or any component of the vaccine.

PRECAUTIONS: Personnel who develop symptoms suggestive of hypersensitivity after an injection should not receive further injections of the vaccine. Personnel with any active infection should delay vaccination until recovered. The vaccine will only be given to pregnant or breast-feeding personnel on the advice and written instruction of their attending obstetric physician.

SIDE EFFECTS: The vaccine is generally well tolerated. No serious adverse reactions attributable to the vaccine have been reported. The most reported reactions have been local injection site reaction (i.e. soreness, and related symptoms), headache, fever, fatigue/malaise, nausea, diarrhea, RI, and pharyngitis.

_____ ___/___/___ _____ ___/___/___
Employee Signature Date Adm. Signature Date

PRIMECARE MEDICAL, INC.

VOLUNTARY SELF-IDENTIFICATION
(CONFIDENTIAL-FOR STATISTICAL USE ONLY)

We are an equal opportunity employer and do not discriminate on the basis of race, color, religion, sex, age, national origin, disability, veteran status, sexual orientation or any other classification protected by federal, state or local law. The information below will be used only in the compilation of data for EEO reporting.

Completion of this data is voluntary and identification can be declared any time after hire. Please return this page with your new hire paperwork.

PLEASE COMPLETE IN FULL:

Facility: _____

Name (Please Print): _____
Sex: (Circle appropriate response) Male Female

RACE/ETHNICITY:
(Please check one of the descriptions below corresponding to the ethnic group with which you most identify.)

___ **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

___ **White (Not Hispanic or Latino)** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

___ **Black or African American (Not Hispanic or Latino)** – A person having origins in any of the black racial groups of Africa.

___ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

___ **Asian (Not Hispanic or Latino)** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

___ **American Indian or Alaska Native (Not Hispanic or Latino)** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

___ **Two or More Races (Not Hispanic or Latino)** – All persons who identify with more than one of the above five races.

Personal and Confidential
This page contains sensitive information, store in secure personnel file.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact PrimeCare Medical, Inc. 1-800-245-7277.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name PrimeCare Medical, Inc.			4. Employer Identification Number (EIN) 23-2428261
5. Employer address 3940 Locust Lane			6. Employer phone number 1-800-245-7277
7. City Harrisburg	8. State PA	9. ZIP code 17109	
10. Who can we contact about employee health coverage at this job? Marcy Hoffman-Schlegel			
11. Phone number (if different from above) same as above		12. Email address mhoffman@primecaremedical.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Those who work 40 hours per week after meeting an initial eligibility period.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse dependents and children dependents.

  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Acknowledgement of Receipt

I, _____, have received Form ***OMB No. 1210-0149*** and my signature below acknowledges receipt of that document.

Employee: _____ Date: _____

Administrator: _____ Date: _____

HOW TO COMPLETE YOUR HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

FOLLOWING ARE INSTRUCTIONS FOR COMPLETING THE HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION. ALL INFORMATION MUST BE COMPLETED AS INDICATED.

EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

1) Employer Name and Reason for Application

2) Employee First Name, Middle Initial, Last Name.

3) Employee Street Address

4) City

5) State

6) Zip Code

7) Employee Social Security Number

8) Effective Date of Coverage

9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee. If retired, please indicate retirement date.

10) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.

11) Employee Work Phone Number (including area code)

12) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).

14) To be completed by Account/Administrator only

Items **15** through **18** ask for important information about yourself and each eligible member of your family (**15** yourself, **16** your spouse/ domestic partner, **17-18** your dependents). Please complete all requested information. If relationship is "other", please indicate the dependent's relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name** — Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **Social Security Number** — Please include the Social Security Number of each person.
- **Do you have other insurance?** — If you or a family member have other medical insurance including Medicare, respond "yes". If not, you must respond "No".
- **Birth Date** (month/day/year)
- **Sex** (female or male)
- **Check if: Student over Maximum Regular Dependent Age, Disabled and/or Act 4 dependent** If your dependent is over the Maximum Regular Dependent Age and is a full time student or a disabled dependent of any age or an Act 4 dependent to the age of 30 (see your benefit administrator for eligibility), please check (✓) the appropriate column by that dependent's name.

Physician of Record (POR) Information — A Physician of Record is the physician selected by the member, who provides routine care and coordinates other specialized care. Please note that choosing a POR does not impact your benefits or claims payment in any way. Choosing a POR simply helps us to better serve you by connecting you to the practice where most of your health care is received.

a) **Full Name of Physician of Record (POR) Group Practice** — Indicate the name of the POR Group Practice selected from the Online Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different POR.

b) **Physician of Record (POR) Number from Provider Directory** — Please indicate the corresponding number for the physician practice you or your dependent chose as a POR from the Online Provider Directory, Practice Information tab.

c) **Are you an existing Patient of this POR?** — Please check "Yes" or "No" to indicate if you are currently a patient of the POR you chose for yourself or your dependents.

For online provider lookup, go to www.highmarkblueshield.com and search under the "Find a Doctor or Rx" tab. If you need assistance with choosing a POR, please call Member Service at 1-800-345-3806.

Disclaimer: Please note that a provider number may not be available for providers that are located outside of the local servicing area. In this case, a POR cannot be chosen.

19) Needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested. Refer to your Medicare card to complete the Medicare Information section.

20) Should be completed by your Account Administrator.

21) You must sign and date the form where indicated.

Once the form is completed, retain the last copy for your records.

HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

HIGHMARK
P.O. Box 890172
Camp Hill, PA 17089

EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.

1) Employer Name — Reason for Application: ❑ New Hire ❑ Rehire ❑ Enrollment ❑ Act 4 ❑ Other: ❑ COBRA

2) Employee First Name / Middle Initial / Last Name

3) Street Address | **4)** City | **5)** State | **6)** Zip

7) Social Security Number | **8)** Effective Date of Coverage Month / Day / Year | **9)** Employee Status ❑ Active ❑ Retired (Date) ❑ Hourly ❑ Salary

10) Employee Phone #—Home ( ) | **11)** Employee Phone #—Work ( ) | **12)** Employee Hire Date Month / Day / Year

13) Check Type of Coverage	**MEDICAL**	**DENTAL**	**VISION**	**DRUG**	**PRODUCT NAME**
Employee Only	❑	❑	❑	❑	❑
Insured & Spouse/Domestic Partner	❑	❑	❑	❑	❑
Family	❑	❑	❑	❑	❑
Parent & Child	❑	❑	❑	❑	❑
Parent & Children	❑	❑	❑	❑	❑

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo / Dy / Yr	Sex F/M	Check If: Student Benefits Apply	Disabled	Act 4
15) Self			❑ Yes ❑ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Are you an Established Patient? ❑ Yes ❑ No					
16) ❑ Spouse ❑ Dom. Part.*			❑ Yes ❑ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Spouse/DP an Established Patient? ❑ Yes ❑ No					
17) ❑ Child ❑ Other*			❑ Yes ❑ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Dependent an Established Patient? ❑ Yes ❑ No					
18) ❑ Child ❑ Other*			❑ Yes ❑ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Dependent an Established Patient? ❑ Yes ❑ No					

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner**

19) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: _____

Group No: _____ Effective Date: _____

Name of Policy Holder: _____

Policy Number: _____

Relationship to Highmark Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Employment Status: ❑ Active ❑ Retired (Date) _____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ❑ Age ❑ Disability ❑ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ❑ Yes ❑ No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application 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, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

20) _____ Authorized Employer Signature — Date

21) _____ Employee Signature — Date

MARGINAL WORDS

HIGHMARK® HEALTH INSURANCE COMPANY

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

❑ **ENROLLING** (Complete sections I, II, IV, and V)

❑ **WAIVING** (Complete sections I and III)

I. APPLICANT INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

Last Name	First Name	MI	Social Security No. — —

Address

City	State	Zip	County	Home/Cell Phone

Marital Status (Please check one):
❑ Single/Widowed
❑ Married
❑ Divorced

Enrollment Status
❑ Active Employee ❑ Rehired Employee
❑ COBRA/mini-COBRA ❑ Act 4 Dependent

Date of Full-Time Hire or Rehire
Mo Day Yr

Hours Worked Per Week

❑ COBRA/mini-COBRA
Start Date _____ End Date _____

COBRA/mini-COBRA REASON: ❑ Deceased ❑ Involuntary Lay-Off ❑ Left Employment
❑ Other _____ Date of Event _____

II ENROLLMENT INFORMATION AND COVERAGE SELECTION (If additional space is required, attach a separate sheet)

APPLICANT

Sex	Date of Birth (Month/Day/Year)	Age	Dependent Status if over Age 26 ❑ Act 4
❑ Male ❑ Female	/ /		If Act 4 Dependent, provide: Employee (parent) Name _____ and Social Security No. ___ — ___ — ____

Product Selection: ❑ Medical Product Name: _____ ❑ Vision ❑ Dental

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___ / ___ / ___ (Month/Day/Year)

DEPENDENT #1

First Name	MI	Last Name	Relationship to You? ❑ Spouse ❑ Dom. Part.

Social Security Number (If no SS#, write N/A) — —	Sex ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age

Product Selection: ❑ Medical ❑ Vision ❑ Dental

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___ / ___ / ___ (Month/Day/Year)

DEPENDENT #2

First Name	MI	Last Name	Relationship to You?* ❑ Child ❑ Step-child

Social Security Number (If no SS#, write N/A) — —	Sex ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age

Product Selection: ❑ Medical ❑ Vision ❑ Dental

Dependent Status if over Age 26
❑ Disabled

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___ / ___ / ___ (Month/Day/Year)

*Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this Application if the relationship between the applicant and child is anything other than biological, and may also be required in other instances.

DEPENDENT #3

First Name	MI	Last Name	Relationship to You?* ❑ Child ❑ Step-child
Social Security Number (If no SS#, write N/A) — —	Sex ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age
Product Selection: ❑ Medical ❑ Vision ❑ Dental		Dependent Status if over Age 26 ❑ Disabled	

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly?_____/_____/_____ (Month/Day/Year)

DEPENDENT #4

First Name	MI	Last Name	Relationship to You?* ❑ Child ❑ Step-child
Social Security Number (If no SS#, write N/A) — —	Sex ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age
Product Selection: ❑ Medical ❑ Vision ❑ Dental		Dependent Status if over Age 26 ❑ Disabled	

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly?_____/_____/_____ (Month/Day/Year)

*Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this Application if the relationship between the applicant and child is anything other than biological, and may also be required in other instances.

III WAIVER OF COVERAGE (Complete this section ONLY if you wish to decline coverage offered for you AND/OR family member(s))

EMPLOYEE MUST SIGN BELOW

MEDICAL		VISION	DENTAL
I HEREBY DECLINE MEDICAL COVERAGE: ❑ For myself ❑ For family members **ONLY**: ❑ For myself and **ALL** family members ❑ For the following family members: _____	**REASON FOR DECLINING MEDICAL COVERAGE:** ❑ Insured under spouse's contract with the following insurance carrier: _____ ❑ Other: _____	**I HEREBY DECLINE VISION COVERAGE:** ❑ For myself ❑ For family members **ONLY** ❑ For myself and **ALL** family members ❑ For the following family members: _____	**I HEREBY DECLINE DENTAL COVERAGE:** ❑ For myself ❑ For family members **ONLY** ❑ For myself and **ALL** family members ❑ For the following family members: _____

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

Employee Signature Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV ABOUT OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policy Holder
Policy Holder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status ❑ Active ❑ Retired - List Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V IMPORTANT: EMPLOYEE MUST SIGN BELOW

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark Health Insurance Company and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

Any person who knowingly and with intent to defraud any insurance company or other person files an application 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, which is a crime and subjects such person to criminal and civil penalties.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Inc. may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Inc.'s Notice of Privacy Practices is available on Highmark Inc.'s Web site, or from the Highmark Inc. Privacy Office.

Print Company Name

Employee Signature

Date

Print Employee's Name

For New Business:
Highmark Health Insurance Company
Small Group Sales
120 Fifth Avenue, Suite P2504
Pittsburgh, PA 15222

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **PRMCARE**	GROUP POLICY #: **000010068392, 000010184113, 000010116368, 000400001000-10071**	Billing Division or Location: **323791, 850524**

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) PrimeCare Medical, Inc.			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage			Amount of Coverage	Per Pay Period (26 weeks)
		Basic Group Life/AD&D	☒Yes	☐No	$	Employer Paid
		Voluntary Short Term Disability	☐Yes	☐No	$	$
		Voluntary Long Term Disability	☐Yes	☐No	$	$

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy. Premiums are calculated from the specific rate matrix and they are based on bi-weekly premium (26 pays)

TYPE OF COVERAGE			AMOUNT OF COVERAGE	Per Pay Period (26 weeks)
Voluntary Employee Life/AD&D Insurance	☐Yes	☐No	$	$
Voluntary Spouse Life/AD&D Insurance	☐Yes	☐No	$	$
Voluntary Dependent Child Benefit	☐Yes	☐No	☐ 10,000	$

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ☐ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION 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, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____