

Employee Enrollment Form



To speed the enrollment process, please be thorough and fill out all sections that apply.

Group Name/Number

To Be Completed by Employer		Requested Effective Date of Coverage/Date of Change	
Date of Hire	/ /	/ /	
Position/Title	Reason for Application		Employee Type
Hours Worked per week	<input type="checkbox"/> New Group Plan	<input type="checkbox"/> New Hire	(Check all that apply)
Salary \$ _____ Required only if Life Plan based on salary	<input type="checkbox"/> Life Event/Date _____	<input type="checkbox"/> Annual	<input type="checkbox"/> Active <input type="checkbox"/> COBRA/State Continuation
	<input type="checkbox"/> Status Change _____	<input type="checkbox"/> Open Enrollment	Start dt ___/___/___ End dt ___/___/___
	<input type="checkbox"/> Dependent Add/Delete	<input type="checkbox"/> Late Enrollee	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____
	<input type="checkbox"/> Change Name/Address		<input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired
	<input type="checkbox"/> Other _____		

A. Employee Information

Last Name		First Name		MI	Social Security Number		Home Phone
							Work Phone
Address			Apt #	City	State	Zip Code	Email Address
Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?		Language preference, if not English	
/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Marital Status		Physician* (First & Last Name)/ ID #			Primary Care Dentist (First & Last Name)/ ID #		
<input type="checkbox"/> Single <input type="checkbox"/> Married							
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed							

B. Family Information

List All Enrolling (Attach sheet if necessary)			Physician* (Name/ID#)		Tobacco Used	
Last Name	First Name	MI	Sex	Relationship**	Primary Care Dentist (Name/ID#)	
			M	Spouse		<input type="checkbox"/> Yes
			F			<input type="checkbox"/> No
			M	Dependent		<input type="checkbox"/> Yes
			F			<input type="checkbox"/> No
			M	Dependent		<input type="checkbox"/> Yes
			F			<input type="checkbox"/> No
			M	Dependent		<input type="checkbox"/> Yes
			F			<input type="checkbox"/> No

*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents, for UnitedHealthcare Select, Select Plus, and other products requiring a Primary Physician designation only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection. Dual Option Plan Selected

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Medical	Dental
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Life Insurance Beneficiary's Full Name and Address	Relationship

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company of Ohio or United HealthCare of Ohio, Inc.
Dental coverage provided by United HealthCare Insurance Company of Ohio or United HealthCare of Ohio, Inc.
Life Insurance coverage provided by United HealthCare Insurance Company of Ohio or Unimerica Insurance Company
Vision coverage provided by United HealthCare Insurance Company of Ohio or Unimerica Insurance Company

D. Prior Medical Insurance Information**This section must be completed to receive credit for prior medical coverage.**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

 NO YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: Employee Spouse Child(ren) Family**E. Other Medical Coverage Information****This section must be completed. (Attach sheet if necessary.)**On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at workAre you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date ___/___/___

Medicare – Spouse/Dependent Name: _____

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form. Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.** Yes No In the last 10 years have you or any member of your family listed on this application been treated for a serious illness?

Examples include, but are not limited to any of the following: cancer, diabetes, multiple sclerosis, HIV/AIDS, mental/nervous disorders, congenital birth defects, organ or other transplants, hemophilia, diseases of the liver, kidney, lungs, heart/circulatory system; or has anyone had surgery or incurred medical/pharmacy claims in excess of \$5,000 or is anyone currently pregnant?

If yes, please provide details on next page.**Please give details to any "yes" answer above.****(If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)**

Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

Confidentiality

Make sure your employer has completed the “To be completed by the employer” section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



Your rights and responsibilities



Important information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete, and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at myuhc.com[®].

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do

we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Pre-existing conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.

I authorize any required premium contributions to be deducted from earnings.