

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

- Enroll     Address Change  
 Cancel     Name Change  
 Change    Date of Change \_\_\_/\_\_\_/\_\_\_

**A. Employee Information**

First Name	M.I.	Last Name	Social Security #/Employee ID #			
Street Address	Apt. #	City	County	State	Zip	Country
Home Phone	Work Phone		How many hours do you work per week?		E-mail Address <input type="checkbox"/> Home <input type="checkbox"/> Work	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Physician*		Physician's ID No.	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

**B. Family Information**

**Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)**

Check appropriate box	Last Name	First Name	M.I.	Sex	Birthdate	Relationship**	Full-Time Student	Physician*	Are you a Current Patient?
	Dependent Social Security No.							Physician's ID Number	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <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 and Select Plus 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 separate sheet.

**C. Product Selection (check all that apply)**

<b>MEDICAL BENEFITS:</b> <input type="checkbox"/> Employee Only Coverage <input type="checkbox"/> Employee/Spouse Coverage <input type="checkbox"/> Employee/Children Coverage <input type="checkbox"/> Employee/Spouse/Children Coverage <input type="checkbox"/> No Medical Coverage (complete Section E)	<b>DENTAL BENEFITS:</b> <input type="checkbox"/> Employee Only Coverage <input type="checkbox"/> Employee/Spouse Coverage <input type="checkbox"/> Employee/Children Coverage <input type="checkbox"/> Employee/Spouse/Children Coverage <input type="checkbox"/> No Dental Coverage <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my spouse <input type="checkbox"/> I decline coverage for my child(ren) Reason: <input type="checkbox"/> Covered under another plan <input type="checkbox"/> Other: _____	<b>LIFE INSURANCE PRODUCTS</b> Salary \$ _____ <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr <input type="checkbox"/> Life/Accidental Death or Dismemberment <input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Suppl. Accidental Death and Dismemberment Life Beneficiary's Full Name and Address _____ Relationship _____	<b>EMPLOYER USE ONLY</b> _____ _____ _____ _____
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**OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)**

- UnitedHealthcare Overture Classic   
  UnitedHealthcare Overture Performance   
  UnitedHealthcare Overture Premier

**D. To Be Completed By Employer**

Company Name	Group #	Plan Variation	Medical _____ Dental _____	Reporting Code	Medical _____ Dental _____	Department #
<input type="checkbox"/> <b>New Enrollment/Additions: (Check one)</b> Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ (attach COBRA Election Form) <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Court ordered dependent (attach documentation) <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___/___/___			<input type="checkbox"/> <b>Cancellations:</b> Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel listed above – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____			

**Product Selections – Check all that apply**

<input type="checkbox"/> UnitedHealthcare Choice <input type="checkbox"/> UnitedHealthcare Select HMO <input type="checkbox"/> UnitedHealthcare Managed Indemnity <input type="checkbox"/> UnitedHealthcare Select Plus POS <input type="checkbox"/> UnitedHealthcare Pinnacle PPO <input type="checkbox"/> UnitedHealthcare Overture Package: _____ (A-S)	<input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> UnitedHealthcare Choice Plus <input type="checkbox"/> UnitedHealthcare Select EPO <input type="checkbox"/> UnitedHealthcare Options PPO <input type="checkbox"/> UnitedHealthcare Select Plus HMO <input type="checkbox"/> UnitedHealthcare Rhapsody	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Active <input type="checkbox"/> Retired/Date _____ <b>DENTAL PLANS</b> <input type="checkbox"/> UnitedHealthcare Dental Managed Indemnity <input type="checkbox"/> UnitedHealthcare Dental Options PPO <input type="checkbox"/> UnitedHealthcare Dental Select DHMO***
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Social Security No. - -

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section D. 3) Please provide your signature and today's date.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer Position \_\_\_\_\_ Phone Number \_\_\_\_\_

**E. Other Medical Coverage Information / Waiver (This section must be completed)**

Have you or your dependents had any other medical coverage in the last 12 months?  YES  NO Will this coverage be terminated?  YES  NO

Insurance Company Name (use extra paper if needed) Coverage Start Date Coverage Stop Date If Yes, Date

Coverage type:  Group Policy  Individual Policy  Medicare/Medicaid  Other

Is this coverage through your spouse's employer?  YES  NO If yes, please provide employer's name Name, date of birth and Social Security # of policy holder

Employee's relationship to policyholder Names of family members with other continuing medical coverage (Including Medicare)

Medicare effective date Parts A&B Reason for Medicare eligibility:  Over 65  Disabled  Kidney Disease Medicare Claim #

**WAIVER** I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:  Existence of other health coverage  Spousal coverage  Other Reason (Explain) \_\_\_\_\_ Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information" located on the back of this form.

X Employee Signature \_\_\_\_\_ (only sign if you are waiving coverage) Date Signed \_\_\_\_\_

**Signature (Form must be signed)**

I confirm that the information I have provided on this form is complete and accurate. I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes. I acknowledge that I have received the "Important Information" statement which is included on the back of this form. I understand that submission of an application or filing a claim containing a false or deceptive statement, with intent to defraud or to facilitate a fraud against an insurer, constitutes insurance fraud.

Date \_\_\_\_\_ Employee Signature \_\_\_\_\_ Spouse Signature \_\_\_\_\_ (if possible) and applicable