Employee Enrollment Form

UnitedHealthcare
A UnitedHealth Group Company

Groups with 51-99 Employees

Group Name/Number

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

To Be Completed by Employer

Requested Effective Date of Coverage/Date of Change / /

Date of Hire / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life Plan based on salary

Reason for Application
☐ New Group Plan ☐ New Hire
☐ Life Event/Date_____ ☐ Annual Open Enrollment
☐ Status Change_____
☐ Dependent Add/Delete
☐ Change Name/Address ☐ Late Enrollee
☐ Other_____

Employee Type (Check all that apply)
☐ Active ☐ COBRA/State Continuation Start dt __/__/__ End dt__/__/__
☐ Hourly ☐ Salary ☐ Other _____
☐ Union ☐ Non-Union ☐ Retired

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 ☐ M ☐ F	Height	Weight	Physician* (First & Last Name)	Used tobacco in the last 12 months? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language preference, if not English

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI / Social Security Number	Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (First and Last Name)	Tobacco Used
_ _	M F	Spouse						☐ Yes ☐ No
_ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ No
_ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ No
_ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ No
_ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ 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.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐					

Life Insurance Beneficiary's Full Name and Address

Relationship

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical/Dental coverage provided by United HealthCare Insurance Company
Life Insurance coverage provided by United HealthCare Insurance Company
Vision coverage provided by United HealthCare Insurance Company

D. 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	End Date	Name and date of birth of policyholder for other coverage
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 work

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.

E. 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 3 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 below.**

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

F. Waiver of Coverage

I decline coverage for:
- ☐ Myself
- ☐ Spouse
- ☐ Dependent Children
- ☐ Myself and all dependents

Declining coverage due to existence of other coverage:
- ☐ Spouse's Employer's Plan
- ☐ Individual Plan
- ☐ Covered by Medicare
- ☐ Medicaid
- ☐ COBRA from Prior Employer
- ☐ VA Eligibility
- ☐ Tri-Care
- ☐ I (we) have no other coverage at this time
- ☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Employee Initials	Date

G. Signature

I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying UnitedHealthcare and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response is accureate and truthful. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates 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 this 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. Please maintain a copy of this authorization for your records.

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No

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

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 insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the 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 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 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.

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guide

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 **www.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 is accurate and truthful.

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