

# Employee Enrollment Form

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 / /

Group Name/Policy Number

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

**A. Employee Information** If you are waiving all coverage, please complete sections A and G.

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

**B. Family Information** List All Enrolling (Attach sheet if necessary)

Last Name	First Name	MI	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#)	Primary Care Dentist** (Name/ID#)	Tobacco Used
			M F	Spouse [/Domestic Partner]						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents.  
 \*\*Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. \*\*\*For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":  
 Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia or UnitedHealthcare Insurance Company of the River Valley  
 Dental coverage provided by UnitedHealthcare Insurance Company  
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company  
 Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name \_\_\_\_\_

**C. Product Selection**

**Please check the box for each coverage you or your dependents are enrolling in.**

If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Employee	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Spouse [Domestic Partner]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____

Person	STD	STD Buy Up	LTD	LTD Buy Up	
Employee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	

Life Insurance Beneficiary's Full Name and Address	Relationship
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**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 (chosed not to enroll)\*\*

Enrolled in Part B: Effective Date \_\_\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chosed not to enroll)\*\*

Enrolled in Part D: Effective Date \_\_\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chosed not to enroll)\*\*

Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at work

Are 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 (chosed not to enroll)\*\*

Enrolled in Part B: Effective Date \_\_\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chosed not to enroll)\*\*

Enrolled in Part D: Effective Date \_\_\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chosed 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.

<b>F. Waiver of Coverage</b>		Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Other _____	I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.
I decline all coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents			
Date	Employee Signature if waiving coverage		

**G. Signature**

I authorize UnitedHealthcare 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, 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 my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that 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 must be complete and accurate. 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.

UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

I have been informed about: 1) the number, mix and distribution of network providers; 2) the existence of limitations and disclosures pertaining to my choice of certain healthcare providers; and 3) that UnitedHealthcare and its Affiliates have contracted with certain healthcare providers and facilities to provide these services on a negotiated basis. I understand that provider reimbursements will not include any incentives or disincentives for providers that order or provide less than appropriate care to their patients or for denying, reducing, limiting or delaying such care.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
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**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