

Enrollment Application and Change Form

PLEASE READ INSTRUCTIONS ON REVERSE SIDE.



New Coverage Request for Change

EMPLOYEE INFORMATION					
Last Name		First Name		MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address			City	Date of Birth	
Employer Name			Division/Location	State	Social Security Number
				Zip Code	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
				Home Phone Number () ()	
				Work Phone Number () ()	

2 TYPE OF MEDICAL COVERAGE		3 WHO SHOULD BE COVERED		4 TYPE OF CHANGE	
<input type="checkbox"/> Choice <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents Reason: <input type="checkbox"/> covered under another plan <input type="checkbox"/> Other: _____ (see sections 6&7)		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Employee Plus Family		<input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec. 5) <input type="checkbox"/> Terminate All Coverage - Reason _____ <input type="checkbox"/> Other _____	
<i>*Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.</i>		<input type="checkbox"/> Reinstatement - Reason _____ <input type="checkbox"/> Surviving Spouse - Former Employee SSN _____ <input type="checkbox"/> COBRA Continuee - Former Employee SSN _____ <input type="checkbox"/> Other _____			

5 COVERAGE INFORMATION								
(A) Add (T) Term (C) Chg.	Last Name	First Name	MI	Social Security Number	Date of Birth (MM/DD/YY)	Plan #	HSA Y N	Deduction Amount
	Employee							\$
	Spouse							
	Child 1							
	Child 2							
	Child 3							

6 OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy, including another United HealthCare plan, Medicare or Medicaid? Y N
 Is another person legally responsible for coverage for your child(ren)? Y N
 If you answered yes to either of the questions above, please complete the following:
 Person's Name with Other Health Plan _____ Social Security Number _____

7 AUTHORIZATION

On behalf of anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates, (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes, I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the insurer or Plan Administrator after it has been approved by the insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct, (if my employee's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution and /or HSA deduction from my pay if applicable. I canceled this direction in writing at any time).

NOTICE OF ENROLLMENT RIGHTS
 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. 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Health insurance or medical services/benefits provided or administered by United HealthCare Insurance Company, Minneapolis, MN

8 TO BE COMPLETED BY EMPLOYER					
Date of Hire	Date Submitted	Health/Change Eff. Date	Policy Number	Signature	GRP/SUBGRP/INT/GRP
				Reporting Code/Branch	Plan Variation/Sub
				Employer Signature	
				Date	