

# 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  
Hours Worked per week  
Salary \$ \_\_\_\_\_ Required only if Life Plan based on salary

Reason for Application  
 New Group Plan  
 Life Event/Date \_\_\_\_\_  
 Status Change  
 Dependent Add/Delete  
 Change Name/Address  
 Other \_\_\_\_\_  
 New Hire  
 Annual Open Enrollment  
 Late Enrollee

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 Used tobacco in the last 12 months?  Yes  No Language preference, if not English

Marital Status  Single  Married  Divorced  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	Full Time Student	Physician* (Name/ID#)	Tobacco Used
Social Security Number									Primary Care Dentist (Name/ID#)	
			M	Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			M	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			M	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<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, 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 or United HealthCare of the Midwest, Inc.

Dental coverage provided by United HealthCare Insurance Company or United HealthCare of the Midwest, Inc. or Dental Benefit Providers of Illinois, Inc.

Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

Vision coverage provided by United HealthCare Insurance Company 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 \_\_\_\_\_

Table with 5 columns: 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. Rows include Employee, Spouse Name, and two Dependent Name entries.

\*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
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 (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 \_\_\_\_\_

Has anyone on this application consulted with or been examined or treated by any health care professional during the last 10 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. I understand the purpose of the disclosure and use of my information is to allow The Company and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. 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.

Table with 2 columns: Category (1 Cancer, 2 Heart/Circulatory, 3 Reproductive, 4 Intestinal/Endocrine, 5 Brain/Nervous, 6 Immune, 7 Lung/Respiratory) and list of medical conditions with checkboxes.

**F. Medical History (continued)**

<b>8 Eyes/Ears/Nose/Throat</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____
<b>9 Urinary/Kidney</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
<b>10 Bones/Muscles</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/CFS <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other _____
<b>11 Behavioral Health</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpat ETOH/Drug <input type="checkbox"/> Inpat MH Hosp <input type="checkbox"/> Other _____
<b>12 Transplant</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications Year _____ <input type="checkbox"/> Other _____
<b>13 Medication</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications Please List Meds _____ <input type="checkbox"/> Medications Taken Within The Past Year Please List Meds _____
<b>14 Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised <input type="checkbox"/> Pending Test Results <input type="checkbox"/> Inpat Hosp/Surg in Past Yr. <input type="checkbox"/> Pending w/c claim <input type="checkbox"/> Tests Advised or Recommended <input type="checkbox"/> Refer to Specialist <input type="checkbox"/> Disability

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

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

<b>G. Waiver of Coverage</b> 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	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 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.
	Date _____	Employee Signature if waiving coverage _____

**H. 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 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. 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.

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