

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

Date of Hire / /	Reason for Application <input type="checkbox"/> New Group Plan <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Waiving Coverage <input type="checkbox"/> Termination <input type="checkbox"/> Other _____	Employee Type (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	Spouse [/Domestic Partner]						<input type="checkbox"/> Yes
			F							
			M	Dependent						<input type="checkbox"/> Yes
			F							
			M	Dependent						<input type="checkbox"/> Yes
			F							
			M	Dependent						<input type="checkbox"/> Yes
			F							

*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":
 UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
 Dental coverage provided by UnitedHealthcare Insurance or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
 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.

G. Waiver of Coverage	
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 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.	
Date	Employee Signature if waiving coverage

H. 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 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.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
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I. 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