Fully Insured Key Account Groups

Enrollment Application/Change/Cancellation Request

UnitedHealthcare®
A UnitedHealth Group Company

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

If waiving medical coverage, please see Section E.

☐ Enroll ☐ Cancel ☐ Change

☐ Address Change ☐ Name Change

Date of Change____ /___ /____

A. Employee Information

First Name	M.I.	Last Name	Social Security #/Employee ID #

Street Address	Apt. #	City	County	State	Zip	Country

Home Phone	Work Phone	How many hours do you work per week?	Coverage Types ☐ Medical ☐ Dental ☐ Vision

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Sex ☐ M ☐ F	Birthdate	Physician*	Physician's ID No.	Are you a current patient? ☐ Yes ☐ No

B. Family Information

Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Last Name / First Name / M.I. / Dependent Social Security No.	Sex	Birthdate	Relationship**	Full-Time Student***	Cov. Type	Physician* / Physician's ID Number	Are you a Current Patient?
☐ Enroll ☐ Cancel ☐ Change	SS# | | | |–| | |–| | | |	M F			☐ Yes ☐ No School Name:	☐ M ☐ D ☐ V		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | |–| | |–| | | |	M F			☐ Yes ☐ No School Name:	☐ M ☐ D ☐ V		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | |–| | |–| | | |	M F			☐ Yes ☐ No School Name:	☐ M ☐ D ☐ V		☐ 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 and Select Plus only (HMO only). **Your employer may have guidelines that require legal documentation from you for court ordered dependents or other information in order to make other eligibility determinations. UnitedHealthcare does not require copies of legal documents. Please see employer representative for more information about these qualifications. If dependent does not have legal residence, please provide address on separate sheet. ***Student verification may be requested for Over Age Dependents upon presentment of a claim, or at any time.**

C. Product Selection *(check all that apply)

*Plan offerings are dependent upon employer election.

☐ Medical Plan - If your employer offers you a choice of medical plans (i.e. Choice Plus POS, Options PPO), please write your medical plan selection here: ________________________ .

☐ Dental Plan - If your employer offers you a choice of dental plans (i.e. Dental Managed Indemnity) please write your dental plan selection here: ________________________ .

☐ Comprehensive Vision Plan

LIFE INSURANCE PRODUCTS

Salary $______________ ☐ wk ☐ mo ☐ yr

Flat Amount $______________

☐ Life/Accidental Death or Dismemberment
☐ Spouse Life Insurance
☐ Dependent Life Insurance
☐ Supplemental Life
☐ Suppl. Accidental Death and Dismemberment
☐ Critical Illness

Life Beneficiary's Full Name and Address

Relationship

D. Other Medical Coverage Information **(This section must be completed)**

On the day your 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 ☐ NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date

Coverage type: ☐ Group Policy ☐ Individual Policy ☐ Medicare/Medicaid ☐ Other__________

Is this coverage through your spouse's employer? ☐ YES ☐ NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)

Medicare effective date Parts A&B	Reason for Medicare eligibility: ☐ Over 65 ☐ Disabled ☐ Kidney Disease	Medicare Claim #

continued on reverse

Applicant Name _____

E. Waiver of Medical Coverage (This section must be completed if declining medical coverage)

WAIVER **I decline to enroll for medical coverage for myself, my spouse, and my dependent children due to:**

☐ Existence of other health coverage ☐ Spousal coverage ☐ Other Reason (Explain) _____

Check one of the above boxes, then read and sign.

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 and may apply at next open enrollment period. 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 31 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 dependent provided that I request enrollment within 31 days after such marriage, birth, adoption, or the date I become party to a suit in which the insured seeks to adopt the child. I have read and understand the "Important Information"located on the back of this form.

X Employee Signature_____ Date Signed_____

(only sign if you are waiving coverage)

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date _____ **Employee Signature** _____ **Spouse Signature** _____

(if possible) and applicable

G. To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section G. 3) Please provide your signature and today's date.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____	Medical _____ Vision _____	Life/AD&D _____ Suppl. Life _____
Dental _____ Life _____	Dental _____ Life _____	Spouse Life_____ Suppl. AD&D _____
UnitedHealthcare Overture Package _____ (A-S)		Dep. Life _____ Critical Illness _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption (attach legal documentation)
☐ Court ordered dependent (attach documentation)
☐ Other (describe) _____
☐ COBRA/Continuation start date _____ stop date_____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel listed above – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached student/dependent max age
☐ Other (describe)_____

	☐ Union ☐ Non-union	☐ Salaried ☐ Hourly	☐ Active ☐ Retire Date _____

Signature _____ Date _____

Employer Position_____ Phone Number_____

Applicant Name _____

IMPORTANT INFORMATION - Detach and retain this page for your records.

In order to make choices about your health care 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 do not answer your questions. Further information is available at www.[xxx].com, 1-800-[xxx-xxxx] or [name of employer/agent contact.]

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 may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.
4. 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.
5. 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.
6. 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 with you. If they do not, we encourage you to talk to your physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage.

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) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/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 HMO/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 form. I (we) know that I (we) have the right to ask for and to 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 health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Medical Coverage. I (we) understand that the HMO/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 this Request for Medical Coverage and any attachments.

Group Medical Insurance provided by or through:
United HealthCare Insurance Company/UnitedHealthcare of Texas, Inc.