Employee Enrollment Form

UnitedHealthcare
A UnitedHealth Group Company

☐ United HealthCare Insurance Company ☐ United HealthCare of the Midlands, Inc.
☐ UnitedHealthcare Plan of the River Valley, Inc. ☐ UnitedHealthcare Insurance Company of the River Valley

Group Name/Number

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** / /

Date of Hire / /
Position/Title
Hours Worked per week
Salary $_____ Required only if Life Plan based on salary

Reason for Application
☐ New Group Plan ☐ New Hire
☐ Life Event/Date_____ ☐ Annual Open Enrollment
☐ Status Change_____
☐ Dependent Add/Delete
☐ Change Name/Address ☐ Late Enrollee
☐ Other_____

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	Physician* (First & Last Name)	Used tobacco in the last 12 months? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language preference, if not English

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI / Social Security Number	Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (First and Last Name)	Tobacco Used
_ _ _	M F	Spouse						☐ Yes ☐ No
_ _ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ No
_ _ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ No
_ _ _	M F	Dependent				☐ Yes ☐ No		☐ Yes ☐ No
_ _ _	M F	Dependent				☐ Yes ☐ No		☐ 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, 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.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐					

Life Insurance Beneficiary's Full Name and Address

Relationship

Coverage provided by "United Healthcare and Affiliates"
Medical/Dental coverage provided by United HealthCare Insurance Company, United HealthCare of the Midlands, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc. (HMO)
Life Insurance coverage provided by United HealthCare Insurance Company
Vision Insurance provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley

Employee Enrollment for Additional Dependents

UnitedHealthcare
A UnitedHealth Group Company

Employee Name ______________________________ SSN ___-__-____

Last Name First Name MI / Social Security Number	Sex	Relationship	Birthdate	Height	Weight	Full Time Student	*Physician (First and Last Name)	Tobacco Used
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No
___-__-____	M F					☐ Yes ☐ No		☐ Yes ☐ No

Health information for dependents listed on this addendum, if required for enrollment, has been included in the Medical History section of the Employee Enrollment Form.

Date	Employee Signature	Spouse Signature (if possible and applicable)

D. 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	End Date	Name and date of birth of policyholder for other coverage
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 (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

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.

E. 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 5 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. **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.**

1 Cancer ☐ Yes ☐ No	☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Other _____ ☐ Testicular ☐ Brain ☐ Ovarian ☐ Cervical ☐ Prostate Stage _____
2 Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Elevated Cholesterol/Triglycerides ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots ☐ Pacemaker ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ Other _____
3 Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date_____) ☐ Multiples (#___) ☐ Pregnancy Complications ☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other _____
4 Intestinal/Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis ☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Other _____
5 Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's Disease ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Tumor ☐ Head Injury ☐ Cyst ☐ Other _____
6 Immune ☐ Yes ☐ No	☐ Scleroderma ☐ ALS ☐ Rheumatoid Arthritis ☐ Psoriasis ☐ Lupus ☐ Immuno Deficiency ☐ Other _____
7 Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis ☐ Sleep Apnea ☐ Other _____
8 Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Other _____
9 Urinary/Kidney ☐ Yes ☐ No	☐ Chronic Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Other _____
10 Bones/Muscles ☐ Yes ☐ No	☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury ☐ Fibromyalgia/CFS ☐ Shoulder Disorder ☐ Knee Disorder ☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other _____
11 Behavioral Health ☐ Yes ☐ No	☐ Anxiety/Depression ☐ ADHD ☐ Bipolar/Manic Depression ☐ Schizophrenia ☐ Autism ☐ Eating Disorder ☐ Suicide Attempt ☐ Inpat ETOH/Drug ☐ Inpat MH Hosp ☐ Other _____
12 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Organ ☐ Discussed Possible Future Transplant ☐ Stem Cell ☐ Transplant Complications Year _____ ☐ Other _____
13 Medication ☐ Yes ☐ No	☐ Current Medications Please List Meds _____ ☐ Medications Taken Within The Past Year Please List Meds _____

(continued on next page)

E. Medical History (continued)

14 Other
☐ Yes ☐ No

☐ Abnormal Test Or Physical Results ☐ Condition Not Mentioned Above
☐ Treatment Or Surgery Discussed Or Advised ☐ Pending Test Results ☐ Inpat Hosp/Surg in Past Yr.
☐ Pending w/c claim ☐ Tests Advised or Recommended ☐ Refer to Specialist ☐ 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

F. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ 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.

Employee Initials	Date

G. 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 UnitedHealthcare and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the 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 24 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 and waiving	Spouse Signature (if applying for coverage)

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