

Employee Enrollment Form



Groups with 51-99 Employees

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	/ /	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"/> Other _____	<input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Late Enrollee	Employee Type (Check all that apply)		
Position/Title	<input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Union			<input type="checkbox"/> COBRA/State Continuation <input type="checkbox"/> Salary <input type="checkbox"/> Non-Union		
Hours Worked per week	Start dt ____/____/____ End dt ____/____/____			<input type="checkbox"/> Other _____ <input type="checkbox"/> Retired		
Salary \$ _____ Required only if Life Plan based on salary						

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	Height	Weight	Physician* (First & Last Name)				Used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
/	<input type="checkbox"/> M <input type="checkbox"/> F									
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					Language preference, if not English					

B. Family Information

List All Enrolling (Attach sheet if necessary)			Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (First and Last Name)	Tobacco Used
Last Name	First Name	MI	M F	Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number										
			M F	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	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

Person	Please check all that apply. Benefit offerings are dependent upon employer selection.								Dual Option Plan Selected
	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	
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
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Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical/Dental coverage provided by UnitedHealthcare of Illinois, Inc., United HealthCare Insurance Company of Illinois, or United HealthCare Insurance Company
 Life Insurance coverage provided by United HealthCare Insurance Company
 Vision coverage provided by United HealthCare Insurance Company

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
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G. Signature

I authorize the Company 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 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 and waiving	Spouse Signature (if applying for coverage)
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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