



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"/> New Hire <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Annual <input type="checkbox"/> Status Change _____ Open <input type="checkbox"/> Dependent Add/Delete Enrollment <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Late <input type="checkbox"/> Part time to Full time Enrollee <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 F.

Last Name		First Name		MI	Social Security Number			
Address		Apt #	City	State	Zip Code	Home/Cell Phone		
Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email Address				Work Phone		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Language Preference, if not English								
Primary Care Physician ² Physician First & Last Name _____ Address _____ ID# _____		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist ³ Dentist First & Last Name _____ ID# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				

B. Family Information List All Enrolling (Attach sheet if necessary)

Relationship ⁴	Last Name	First Name		MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
Spouse /Domestic Partner	Social Security Number		Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Primary Care Physician ² Physician First & Last Name _____ Address _____ ID# _____		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist ³ Dentist First & Last Name _____ ID# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by UnitedHealthcare Insurance Company
 Dental coverage provided by UnitedHealthcare Insurance Company
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
 Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name _____

B. Family/Dependent Information (continued) List All Enrolling (Attach sheet if necessary)

Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number -	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# -	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number -	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# -	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number -	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# -	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number -	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# -	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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C. Product Selection Please check the box for each coverage in which you or your dependents are enrolling. 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	LTD
Employee	<input type="checkbox"/>	<input type="checkbox"/>

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

Employee Name _____

D. Prior Medical Insurance Information

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 (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. Waiver of Coverage

I decline all 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 qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date _____ Employee Signature if waiving coverage _____

