

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

Group Name/Number

**To Be Completed by Employer**

New  Dependent Add/Delete  Change Name/Address  Cancel  Date of Change

**Group Specifics**

Position/Title  
Hours Worked  
Plan Selected  
Medical \_\_\_\_\_  
Dental \_\_\_\_\_

Reason for Application  
 New Group Plan  
 Annual Open Enrollment  
 New Hire  
 Status Change \_\_\_\_\_  
 Life event/date \_\_\_\_\_  
 Other \_\_\_\_\_  
 Date of Hire \_\_\_\_\_

Product Selection  
Health  Yes  No  
Life  Yes  No  
\$ \_\_\_\_\_  
Dep Life  Yes  No  
Dental  Yes  No  
Vision  Yes  No  
Other \_\_\_\_\_

Employee Type  
Active  Yes  No  
COBRA./St Cont  Yes  No  
Hourly  Yes  No  
Salary  Yes  No  
Union  Yes  No  
Non-Union  Yes  No  
Other \_\_\_\_\_

**A. Employee Information**

First Name MI Last Name Social Security Number Home Phone Work Phone  
Address Apt # City State Zip Email Address

**B. Family Information**

List All Enrolling (Attach sheet if necessary) Marital Status  Single  Married

Last Name	First Name	MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time	Physician*(First and Last Name)
Employee			M F	Self				Student	
			M F	Spouse/[Dom. Partner]					
			M F					<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 and Select Plus 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)\* Dual Option Plan Number

Person	Medical	Life	Sup Life	Sup AD&D	Dental	Vision	STD	LTD	Dual Option Plan Number
Employee	\$		\$	\$					
Spouse	\$								
Dependents	\$								

\*Benefit offerings are dependent upon employer election  
Life Beneficiary's Full Name and Address Relationship

**D. Other Coverage Information**

Yes  No Has anyone on this application been covered with health benefits, including coverage with UnitedHealthcare within the past 2 years?  
 Yes  No Are you or any of your dependents covered by Medicare?  
If yes, Name of Medicare Beneficiary Date Medicare became effective Claim Number

**E. Waiver of Coverage**

I decline coverage for:  
 Myself and all dependents  
 Spouse  
 Dependent Children  
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  Other \_\_\_\_\_  
 I (we) have no other coverage at this time  
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

**F. Signature**

I authorize United HealthCare Insurance Company/UnitedHealthcare of New England, Inc. and its affiliates ("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 The Company and Affiliates. I understand the purpose of the disclosure and use of my information is to allow The Company 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 The Company 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.

**F. Signature (continued)**

I (we) understand that I (we) have the right to access and correct any personal information collected. 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 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 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 applicable)
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# Employee Enrollment for Additional Dependents

Employee Name \_\_\_\_\_

Last Name	First Name	MI	Sex	Relationship	Birthdate	Height	Weight	Full Time Student	*Physician (First and Last Name)
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
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			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health information for dependents listed on this addendum, if required for enrollment, has been included in section G (Medical History) of this application.

<b>Date</b>	<b>Employee Signature</b>	<b>Spouse Signature (if possible and applicable)</b>