(DO NOT STAPLE)

Employee Enrollment Form

UnitedHealthcare

UnitedHealthcare Insurance Company
UnitedHealthcare of Texas, Inc.
National Pacific Dental, Inc.
Unimerica Insurance Company
PacifiCare Life & Health Insurance Company

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD 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
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other _____

Employee Type (Check all that apply)
- ☐ Active
- ☐ COBRA Start dt ____/____/____ End dt____/____/____
- ☐ State Continuation
- ☐ Hourly
- ☐ Salary
- ☐ Union
- ☐ Non-Union
- ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and G.

Last Name	First Name	MI	Social Security Number	Home/Cell Phone Work Phone

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth / /	Sex ☐ M ☐ F	Height	Weight	Used tobacco in the last 12 months? ☐ Yes ☐ No	Email Address

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

HMO female enrollees are not required to select an obstetrician or gynecologist. Obstetrical or gynecological care can be received from her primary care physician, primary care provider or an obstetrician or gynecologist.

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
_ _	M F	Spouse/ Domestic Partner					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company (PPO, indemnity), UnitedHealthcare of Texas, Inc. (HMO), or PacifiCare Life & Health Insurance Company (PPO, Indemnity)
Dental coverage provided by UnitedHealthcare Insurance Company (indemnity), National Pacific Dental, Inc. (HMO) or Unimerica Insurance Company (indemnity)
Life, Short-Term Disability (STD), Long-Term Disability (LTD) insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company (PPO, indemnity) or Unimerica Insurance Company (PPO, indemnity)

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse/Domestic Partner	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up	
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____	

Life Insurance Beneficiary's Full Name and Address

Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form. Please answer completely and truthfully. **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.** UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ Yes ☐ No In the last 5 years have you or any member of your family listed on this application been diagnosed or treated by a licensed medical provider for cancer, diabetes, multiple sclerosis, mental/nervous disorders, congenital birth defects or diseases, organ or other transplants, hemophilia, HIV/AIDS, immune disorders, bone/joint disorders, diseases of the liver, kidney, lungs, heart/circulatory system; or is anyone currently pregnant, incurred medical / pharmacy claims in excess of $5,000 or currently undergoing treatment / receiving care for a medical condition not listed above?

Please give details to any "yes" answer above.
(If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)

Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

G. 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. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

H. Signature

I authorize UnitedHealthcare 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 my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that 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	Spouse Signature (if applying for coverage)

I. 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