UnitedHealthcare®

UnitedHealthcare of Arizona, Inc.
1 East Washington Street, Ste. 1700
Phoenix, AZ 85004

Arizona

ENROLLMENT FORM FOR MEDICAL INSURANCE
The information provided in this enrollment form must be true and complete for each applicant.

STEP 1: Select Reason for Enrollment

Select one option: New Enrollment   Add a Dependent*   **Policy Number:**
For additions of dependents, provide the Policy Number

STEP 2: Select Enrollment Period

Select one option: Open Enrollment *(skip to Step 3)*   A Special Enrollment Period through a qualifying life event

Please choose your qualifying life event (select one option):

Loss of health coverage   Gaining or becoming a dependent through marriage

Permanent relocation with access to new plans   Gaining or becoming a dependent through the birth of a child or adoption

Changes in household   Changes in residence

Other Qualifying event

Please list the date of your qualifying life event (MM/DD/YYYY):

STEP 3: Select Plan

Select one option:

Gold   **Plan Name:**

Silver   **Plan Name:**

Bronze   **Plan Name:**

STEP 4: Provide Applicant(s) Demographic and Contact Information

PRIMARY APPLICANT INFORMATION

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account.

If this application is only for a child under age 18, the child is the primary applicant.

First Name: **Middle Initial:**

Last Name:

Social Security Number (SSN) (required)**:**   **I don't have a SSN:**

Date of Birth (MM/DD/YYYY):   **Gender:**   Male   Female

Phone Number (XXX-XXX-XXXX):

Email Address:

**Resident Physical Address (where you live and pay taxes) – Please include apartment / unit number (if applicable).
P.O. Boxes are not accepted:**

City: **State (Abbreviation):**   **Zip Code (XXXXX):**

Mailing Address (if different than Resident Physical Address):

City: **State (Abbreviation):**   **Zip Code (XXXXX):**