

LARGE MEMBER ENROLLMENT/CHANGE FORM

Insurance Products provided by
**UnitedHealthcare
Insurance Company**

**DHMO benefits provided
by Dental Benefit Providers
of Illinois, Inc.

- UnitedHealthcare Choice
- UnitedHealthcare Select HMO
- UnitedHealthcare Managed Indemnity
- UnitedHealthcare Select Plus POS
- UnitedHealthcare Choice Plus
- UnitedHealthcare Select EPO
- UnitedHealthcare Options PPO

A. EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Social Security #	Birthdate
Street Address		Apt. #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone #
City	County	State	Zip	Work Phone #
<input type="checkbox"/> Union <input type="checkbox"/> Salaried <input type="checkbox"/> Non-union <input type="checkbox"/> Hourly			How many hours do you work per week?	E-mail address

B. PRODUCT SELECTION (Check all that apply)

MEDICAL BENEFITS: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family Coverage <input type="checkbox"/> No Employee Coverage* <input type="checkbox"/> No Dependent Coverage*	WAIVER OF COVERAGE SECTION (Must be completed if employee and/or dependents waive health coverage.) Note: If you are declining coverage for yourself or your dependents, because of other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date. <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my spouse <input type="checkbox"/> I decline coverage for my child(ren) - Child Name _____, Child Name _____, Child Name _____ The reason I am not applying for the coverage is: <input type="checkbox"/> Covered under spouse's group plan <input type="checkbox"/> Covered under another group plan - Copy of current carrier's ID card must be attached. Insurance Company Name, Address & Phone No. _____ Policy Number _____ Policyholder's Name _____ Policyholder's SS # _____ <input type="checkbox"/> Relationship to employee _____ <input type="checkbox"/> Other (please explain) _____
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*Must be checked if coverage is waived.

C. OTHER PRODUCT SELECTION

DENTAL BENEFITS: <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> DHMO** <input type="checkbox"/> No Dental Benefits	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family Coverage	LIFE INSURANCE/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Salary (if applicable)\$_____ <input type="checkbox"/> WK <input type="checkbox"/> Mo <input type="checkbox"/> Yr	Beneficiary's Full Name and Address: Relationship _____
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D. FAMILY INFORMATION

Employee and dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Employee/Dependent Social Security No.	Last Name	First Name	M.I.	Principal/Personal Physician (Primary Care Physician) (only applicable for Select/Select Plus)	UnitedHealthcare Physician Number (13 digits)	Birthdate	Relationship**	Student	Sex	Resides w/ employee	Coverage
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change									<input type="checkbox"/> Yes <input type="checkbox"/> No School Name _____	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change									<input type="checkbox"/> Yes <input type="checkbox"/> No School Name _____	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change									<input type="checkbox"/> Yes <input type="checkbox"/> No School Name _____	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change									<input type="checkbox"/> Yes <input type="checkbox"/> No School Name _____	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Principal/Personal Physician (Primary Care) for yourself and each of your covered dependents for UnitedHealthcare Select, Select Plus.
 *Dependents are eligible for coverage if they are the age of 25 or under, dependent upon you for support, AND are living in your household OR are a full-time or part-time student.

E. OTHER MEDICAL COVERAGE INFORMATION

Do you or your dependents have any other medical coverage? YES NO
 Coverage type: Group Policy Individual Policy Medicare/Medicaid If yes fill out this section ►

Insurance Company Name, Address and Phone Number _____ Policy Number _____

Policy Coverage Date _____ to _____	Name of Policyholder _____	Policyholder's Birthdate / /	Family Members Covered by Medical Insurance _____
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Name of family members covered by Medicare _____	Medicare Claim Number _____	Part A Effective Date / /	Part B Effective Date / /	Is Medicare eligibility due to: <input type="checkbox"/> Kidney failure (ESRD) <input type="checkbox"/> Disability <input type="checkbox"/> Retired
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F. WAIVER OF INSURANCE SIGNATURE (Form must be signed)

I understand that if I and/or my dependents, if any, waive health coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X Employee Waiver Signature _____ Date Signed _____

G. TO BE COMPLETED BY EMPLOYER

Company Name _____	Date of Employment _____	Branch Location Code _____	Requested Effective Date _____
Group Number _____	Completed By/Position/Phone Number _____	Date Completed _____	

<input type="checkbox"/> New Enrollment/Additions: (Check one) <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) on ___/___/___ <input type="checkbox"/> Return from Leave/Layoff on ___/___/___ <input type="checkbox"/> Birth on ___/___/___ <input type="checkbox"/> Marriage on ___/___/___ <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Court ordered dependent (attach Qualified Medical Child Support Order) <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Cancellations: <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel listed above-Section D Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Employee now ineligible. <input type="checkbox"/> Dependent now ineligible <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____ Requested Effective Date of Cancellation <input type="checkbox"/> COBRA (Beginning Date _____) <input type="checkbox"/> 18 mo. <input type="checkbox"/> 29 mo. <input type="checkbox"/> 36 mo. <input type="checkbox"/> Florida Health Insurance Coverage Continuation Act (for groups less than 20). <input type="checkbox"/> Beginning Date _____ <input type="checkbox"/> 18 mo. <input type="checkbox"/> 29 mo. <input type="checkbox"/> 36 mo.	<input type="checkbox"/> Address Change Street _____ City _____ State _____ Zip _____ Home Phone _____ <input type="checkbox"/> Name From: _____ To: _____	Requested Effective Date of Change _____
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ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of change,
 1) Please review all sections and confirm employee completed the appropriate information. ► Employer Signature _____ Date _____
 2) Complete section B. 3) Please provide your signature and today's date.

H. IMPORTANT INFORMATION-PLEASE READ CAREFULLY

The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my and/or my dependents' coverage. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I understand that coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. Statements made to this application are representations not warranties. By signing this enrollment form, I hereby certify that all the information provided is true and correct.

I. SIGNATURE (This form must be signed)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as the original. I understand that this health plan may contain a provision which excludes coverage for pre-existing conditions.

X
 Employee Signature _____ Date Signed _____