

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 / /
---------------------------	-----------	------------	----	--	----------------------

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
-----------	-----------------------------------	---

Primary Care Physician²	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Dentist³	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician First & Last Name _____		Dentist First & Last Name _____	
Address _____		ID# _____	
ID# -		Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No	

Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
---------------------------	-----------	------------	----	--	----------------------

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
-----------	-----------------------------------	---

Primary Care Physician²	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Dentist³	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician First & Last Name _____		Dentist First & Last Name _____	
Address _____		ID# _____	
ID# -		Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No	

Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
---------------------------	-----------	------------	----	--	----------------------

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
-----------	-----------------------------------	---

Primary Care Physician²	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Dentist³	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician First & Last Name _____		Dentist First & Last Name _____	
Address _____		ID# _____	
ID# -		Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No	

Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
---------------------------	-----------	------------	----	--	----------------------

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
-----------	-----------------------------------	---

Primary Care Physician²	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Dentist³	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician First & Last Name _____		Dentist First & Last Name _____	
Address _____		ID# _____	
ID# -		Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No	

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
- Covered by Medicare
- COBRA from Prior Employer
- Tri-Care
- I (we) have no other coverage at this time
- Other _____
- Individual Plan
- Medicaid
- VA Eligibility

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 _____

