Enrollment/Change Form

Group Dental Insurance, Vision Care Insurance, Critical Illness Insurance, and Accident Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:
Employer Authorization:	Date of Hire: ___/___/___	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: _____/_____/______		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Birth
☐ Divorce	☐ Dissolution Of Domestic Partnership	☐ Death	☐ Declaration of Domestic Partnership*
☐ Adoption/Legal Custody	☐ Court Ordered Dependent	☐ Cobra/State Continuation	
☐ Other:		Start Date ___/___/___ End Date ___/___/___	

EMPLOYEE INFORMATION

SS# ____________-________-________________	Employer Assigned ID# ____________		Date of Birth: _____/_____/_________
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:	Annual Salary: $

Sex: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Domestic Partner *

Number of hours worked per week: ______________

Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

FAMILY INFORMATION

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No

* A Domestic Partnership is established when both persons have filed a Declaration of Domestic Partnership with the State of California. Please contact your employer for confirmation.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered “Yes” for Incapacitated, please attach medical certification of disability.

Employee Name: Last	First:	Middle Initial:	Date of Birth:

BENEFIT ELECTIONS

Person	Dental	Vision
Employee Spouse (or Domestic Partner) Dependent	☐ ☐ ☐ ☐ Waive (if applicable)	☐ ☐ ☐ ☐ Waive (if applicable)

Person	Critical Illness Insurance	
Employee Spouse (or Domestic Partner) Dependent	Do you and all members of your family who are enrolling for coverage currently have coverage in force under a health benefit plan that covers the costs of your medical care expenses (comprehensive insurance, major medical health insurance, health insurance under an HMO plan, or basic hospital and medical expense insurance)? ☐Yes ☐No If you do not currently have coverage under a health benefit plan that covers the cost of your medical care, you are not eligible for Critical Illness insurance. Critical Illness insurance is not a substitute for plans providing coverage for the essential health benefits and minimum essential coverage defined in federal law.	☐ $_____ ☐Restoration Rider (if applicable) ☐ $_____ ☐ $_____ In the last 24 months have you smoked a cigarette, cigar, chewed tobacco or used tobacco or nicotine in any form? Employee? ☐Yes ☐No Spouse? ☐Yes ☐No ☐ Waive (if applicable)

Person	Accident Insurance	
Employee Spouse (or Domestic Partner) Dependent	☐ Base Benefit ☐ ☐ ☐ Waive (if applicable)	☐ Base + Enhanced Additional Benefits (if applicable) ☐ Additional AD&D ☐ Outpatient Medical Expense ☐ Catastrophic Injury ☐ Waive (if applicable)

BENEFICIARY(IES)* **Beneficiary(ies) to be designated at time of Enrollment.**

Product	Full Name	%	Address	City	State	Zip Code	Relationship
Critical Illness	Primary						
	Secondary/ Contingent						
Accident	Primary						
	Secondary/ Contingent						

* Do not use to change a previously designated Beneficiary. For changes, use the Beneficiary Designation form available from the Employer.

Employee Name: Last	First:	Middle Initial:	Date of Birth:

AUTHORIZATION AND ACKNOWLEDGEMENT

Form must be signed

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

Employee/Enrollee Signature:	Date:

FRAUD WARNING NOTICE

Please review the following notice.

UnitedHealthcare may terminate your coverage and/or deny any claim under an insurance policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your enrollment under the policy.