

Enrollment/Change Form

Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance provided by:

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



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: ___/___/___		<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
Reason: (Check the Appropriate Boxes)	<input type="checkbox"/> New Group Plan	<input type="checkbox"/> New Hire	<input type="checkbox"/> Annual Open Enrollment
	<input type="checkbox"/> Name Change	<input type="checkbox"/> Employee Terminated	<input type="checkbox"/> Marriage
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Dissolution Of Domestic Partnership	<input type="checkbox"/> Birth
	<input type="checkbox"/> Adoption/Legal Custody	<input type="checkbox"/> Court Ordered Dependent	<input type="checkbox"/> Declaration of Domestic Partnership*
	<input type="checkbox"/> Other:	Cobra/State Continuation	
		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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner *		
Number of hours worked per week: _____			
Employee Type (Check all that apply): <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Retired <input type="checkbox"/> Other			

FAMILY INFORMATION

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

Check Appropriate Box	First Name	MI	Last Name (if different)	Date of Birth	Sex	Relationship**	Incapacitated***
	Dependent Social Security Number or Assigned ID						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner*	Not Applicable
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

BENEFIT ELECTIONS				
Person	Basic Life	Basic AD&D	STD	LTD
Employee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> _____ <input type="checkbox"/> Buy-up	<input type="checkbox"/> _____ <input type="checkbox"/> Buy-up
Spouse (or Domestic Partner)	<input type="checkbox"/> \$ _____			
Dependent	<input type="checkbox"/> \$ _____			
	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)
Person	Supplemental Life		Supplemental AD&D	
Employee	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	
Spouse (or Domestic Partner)	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	
Dependent	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	
	<input type="checkbox"/> Waive		<input type="checkbox"/> Waive	
Have you used tobacco of any kind in the past 12 months?				
Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No				

BENEFICIARY(IES)*		Beneficiary(ies) to be designated at time of Enrollment.					
Product	Full Name	%	Address	City	State	Zip Code	Relationship
Life & AD&D	Primary						
	Secondary/ Contingent						

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

AUTHORIZATION AND ACKNOWLEDGEMENT	Form must be signed
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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.

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:
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FRAUD WARNING NOTICE	Please review the following notice.
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For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.