(DO NOT STAPLE)

Employee Enrollment Form
Virginia

UnitedHealthcare®

☐ **UnitedHealthcare Insurance Company** ("The Company")
185 Asylum Street, Hartford, CT 06103

☐ **UnitedHealthcare of the Mid-Atlantic, Inc.** ("The Company")
800 King Farm Boulevard, Rockville, MD 20850

☐ **UnitedHealthcare Plan of the River Valley, Inc.** ("The Company")
1300 River Drive, Suite 200, Moline, IL 61265

☐ **Optimum Choice, Inc.** ("The Company")
800 King Farm Boulevard, Rockville, MD 20850

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer | **Requested Effective Date of Coverage/Date of Change** / /

Group Name

Policy Number

Date of Hire / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
☐ New Group Plan ☐ New Hire
☐ Life Event/Date_____ ☐ Annual Open Enrollment
☐ Status Change_____
☐ Dependent Add/Delete
☐ Change Name/Address ☐ Late Enrollee
☐ Part time to Full time
☐ Waiving Coverage ☐ Termination
☐ Other _____

Employee Type
(Check all that apply)
☐ Active ☐ COBRA ☐ State Continuation
Start dt ____/____/____
End dt____/____/____
☐ Hourly ☐ Salary
☐ Union ☐ Non-Union ☐ Retired
☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and B.

Last Name | First Name | MI | Social Security Number ___ — ___ — ____

Address | Apt # | City | State | Zip Code | Home/Cell Phone

Date of Birth / / | Gender ☐ M ☐ F | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Language Preference, if not English | Work Phone

Email Address

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name _____
Address _____
ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3]
Dentist First & Last Name _____
ID# _____
Existing Patient? ☐ Yes ☐ No

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

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 all coverage

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare Plan of the River Valley, Inc., or Optimum Choice, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name ____________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Spouse or Domestic Partner				☐ M ☐ F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No

Dentist First & Last Name ____________________

ID# ____________________

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐ M ☐ F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐ M ☐ F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐ M ☐ F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐ M ☐ F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the “yes” box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered “Yes” for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of an intellectual disability or physical handicap, illness or condition, please attach a medical certification of disability.

Employee Name _____

D. 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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse or Domestic Partner	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	LTD
Employee	☐	☐

☐ Yes ☐ No Acceptance of this application will replace existing life insurance coverage.

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

E. 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

F. 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.

G. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize "The Company(ies)" checked on page one to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to "The Company(ies)". I understand that the purpose of the disclosure and use of my information is to allow "The Company(ies)" to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my "Company(ies)" representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, "The Company(ies)" also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed (and for the term of coverage of the policy for the purpose of collecting information in connection with reviewing and/or processing a claim for benefits). I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that I am completing a joint life and health application and that each response must be complete and accurate to the best of my knowledge and belief. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that "The Company(ies)" is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective. In accordance with Virginia law, the validity of a policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. In addition, and in accordance with Virginia law, no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1.) After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2.) Unless the statement is contained in a written instrument signed by him. This shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

You or your authorized representative are entitled to receive a copy of this authorization.

Please maintain a copy of this authorization for your records.

I certify that I have read, or have had read to me, this completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No