

# Fully Insured Key Account Groups Enrollment Application/Change/Cancellation Request



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

If waiving medical coverage, please see Section E.

- Enroll  
 Cancel  
 Change
- Address Change  
 Name Change  
 Date of Change \_\_\_/\_\_\_/\_\_\_

## A. Employee Information

First Name	M.I.	Last Name	Social Security #/Employee ID #		
Street Address	Apt. #	City	County	State	Zip Country
Home Phone	Work Phone	How many hours do you work per week?	Coverage Types <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Physician*	Physician's ID No.	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

## B. Family Information

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

Check appropriate box	Last Name	First Name	M.I.	Sex	Birthdate	Relationship**	Full-Time Student***	Cov. Type	Physician*	Are you a Current Patient?
	Dependent Social Security No.								Physician's ID Number	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V		<input type="checkbox"/> YES <input type="checkbox"/> NO

**\*IMPORTANT:** Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care), for yourself and each of your covered dependents for UnitedHealthcare Select and Select Plus only. \*\*Your employer may have guidelines that require legal documentation from you for court ordered dependents or other information in order to make other eligibility determinations. UnitedHealthcare does not require copies of legal documents. Please see employer representative for more information about these qualifications. If dependent does not reside with eligible employee, please provide address on separate sheet. \*\*\*Student verification will be requested for Over Age Dependents upon presentation of a claim.

## C. Product Selection \*(check all that apply)

- \*Plan offerings are dependent upon employer election.
- Medical Plan - If your employer offers you a choice of medical plans (i.e. Choice Plus POS, Options PPO), please write your medical plan selection here: \_\_\_\_\_
- Dental Plan - If your employer offers you a choice of dental plans (i.e. Dental Options PPO, Dental Managed Indemnity) please write your dental plan selection here: \_\_\_\_\_
- Comprehensive Vision Plan

## LIFE INSURANCE PRODUCTS

Salary \$ _____ Flat Amount \$ _____ <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	Life Beneficiary's Full Name and Address
<input type="checkbox"/> Life/Accidental Death or Dismemberment <input type="checkbox"/> Spouse Life Insurance <input type="checkbox"/> Dependent Life Insurance	Relationship
<input type="checkbox"/> Supplemental Life <input type="checkbox"/> Suppl. Accidental Death and Dismemberment <input type="checkbox"/> Critical Illness	

## D. Other Medical Coverage Information (This section must be completed)

On the day your 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  NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date
Coverage type: <input type="checkbox"/> Group Policy <input type="checkbox"/> Individual Policy <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other _____		
Is this coverage through your spouse's employer? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder	
Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)	
Medicare effective date Parts A&B	Reason for Medicare eligibility: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease	Medicare Claim #

**E. Waiver of Medical Coverage**

**(This section must be completed if declining medical coverage)**

**WAIVER** I decline to enroll for medical coverage for myself, my spouse, and my dependent children due to:

- Existence of other health coverage    Spousal coverage    Other Reason (Explain) \_\_\_\_\_

Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. 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. I have read and understand the "Important Information" located on the back of this form.

X Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_  
 (only sign if you are waiving coverage)

**Signature** (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date \_\_\_\_\_ Employee Signature \_\_\_\_\_ Spouse Signature \_\_\_\_\_  
 (if possible) and applicable

**G. To Be Completed By Employer**

**ATTENTION EMPLOYER REPRESENTATIVE:** To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section G. 3) Please provide your signature and today's date.

Company Name _____		Group # _____	Department # _____
<b>Plan Variation</b>		<b>Reporting Code</b>	
Medical _____	Vision _____	Medical _____	Vision _____
Dental _____	Life _____	Dental _____	Life _____
UnitedHealthcare Overture Package _____ (A-S)			
<b>Benefit Level/Class Code, if applicable</b>			
Life/AD&D _____		Suppl. Life _____	
Spouse Life _____		Suppl. AD&D _____	
Dep. Life _____		Critical Illness _____	
<input type="checkbox"/> <b>New Enrollment/Additions: (Check one)</b> Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Court ordered dependent (attach documentation) <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/Continuation start date _____ stop date _____ <input type="checkbox"/> <b>Annual Open Enrollment</b> Requested Effective Date of Enrollment ___/___/___		<input type="checkbox"/> <b>Cancellations:</b> Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel listed above – Section B 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"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____	
		<input type="checkbox"/> Union <input type="checkbox"/> Non-union	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly
		<input type="checkbox"/> Active <input type="checkbox"/> Retire Date _____	

Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer Position \_\_\_\_\_ Phone Number \_\_\_\_\_