



Employee Enrollment Form

- UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103
- Optimum Choice, Inc
800 King Farm Boulevard, Suite 600
Rockville, MD 20850
- Dental Benefit Providers of Illinois, Inc.
Liberty 6, Suite 200
6200 Old Dobbin Lane
Columbia, MD 21045
- UnitedHealthcare of the Mid-Atlantic, Inc.
800 King Farm Boulevard, Suite 600
Rockville, MD 20850
- MAMSI Life and Health Insurance Company
800 King Farm Boulevard, Suite 600
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 / /		Reason for Application		Employee Type	
Position/Title		<input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Annual <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Open <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Enrollment <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Late <input type="checkbox"/> Part time to Full time <input type="checkbox"/> Enrollee <input type="checkbox"/> Waiving Coverage <input type="checkbox"/> Termination <input type="checkbox"/> Other _____		(Check all that apply) <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation Start dt ____/____/____ End dt ____/____/____ <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 _____	
Hours Worked per week					
Salary \$ _____		Required only if Life, STD, or LTD Plan based on salary			

A. Employee Information		If you are waiving all coverage, please complete sections A and F.				
Last Name		First Name		MI	Social Security Number	
Address		Apt #	City	State	Zip Code	Home/Cell Phone
Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email Address			Work Phone	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Language Preference, if not English		
Primary Care Physician ¹ Physician First & Last Name _____ Address _____ ID# _____		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist ² Dentist First & Last Name _____ ID# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(1) For 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. (2) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (3) 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. (4) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, depends mainly on the subscriber for support, and is not able to be self-supporting because of mental or physical incapacity that originated before the dependent attained the limiting age, please attach a medical certification of incapacitation.

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of the Mid-Atlantic, Inc. or Optimum Choice, Inc. or MAMSI Life and Health Insurance Company
 Dental coverage provided by UnitedHealthcare Insurance Company or Dental Benefit Providers of Illinois, Inc.
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) and Accidental Death and Dismemberment (ADD) Insurance coverage provided by UnitedHealthcare Insurance Company
 Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name _____

B. Family/Dependent Information **List All Enrolling (Attach sheet if necessary)**

Relationship ³	Last Name	First Name	MI
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Spouse /Domestic Partner	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Primary Care Physician¹ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist² Dentist First & Last Name _____ ID# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ³	Last Name	First Name	MI
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Dependent	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Primary Care Physician¹ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Disabled and age 26 or older ⁴ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ³	Last Name	First Name	MI
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Dependent	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Primary Care Physician¹ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Disabled and age 26 or older ⁴ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ³	Last Name	First Name	MI
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Dependent	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Primary Care Physician¹ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Disabled and age 26 or older ⁴ <input type="checkbox"/> Yes <input type="checkbox"/> No
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(1) For 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. (2) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (3) 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. (4) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, depends mainly on the subscriber for support, and is not able to be self-supporting because of mental or physical incapacity that originated before the dependent attained the limiting age, please attach a medical certification of incapacitation.

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"/>			

Employee Name _____

C. Product Selection (continued)

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

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	Declining coverage due to existence of other coverage:	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.
I decline all coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents	<input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Other _____	

Date _____ Employee Signature if waiving coverage _____

G. Signature

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") 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 UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare 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 UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare 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.

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 UnitedHealthcare 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.

IT IS A CRIME TO KNOWINGLY PROVIDE, OR TO KNOWINGLY ASSIST, ABET, OR CONSPIRE WITH ANOTHER TO PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE THE COMPANY OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

Please maintain a copy of this authorization for your records.

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