

# 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**       **Address Change**  
 **Cancel**       **Name Change**  
 **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

<b>LIFE INSURANCE PRODUCTS</b>	Life Beneficiary's Full Name and Address
Salary \$ _____ Flat Amount \$ _____ <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	Relationship
<input type="checkbox"/> Life/Accidental Death or Dismemberment <input type="checkbox"/> Supplemental Life	
<input type="checkbox"/> Spouse Life Insurance <input type="checkbox"/> Suppl. Accidental Death and Dismemberment	
<input type="checkbox"/> Dependent Life Insurance <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 \_\_\_\_\_  
(only sign if you are waiving coverage)

Date Signed \_\_\_\_\_

**Signature** (Form must be signed)

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

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 # _____
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Plan Variation	Reporting Code	Benefit Level/Class Code, if applicable
Medical _____ Vision _____ Dental _____ Life _____ UnitedHealthcare Overture Package _____ (A-S)	Medical _____ Vision _____ Dental _____ Life _____	Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____ Dep. Life _____ Critical Illness _____

- New Enrollment/Additions: (Check one)**
- Date of Hire \_\_\_/\_\_\_/\_\_\_ Requested Date of Coverage \_\_\_/\_\_\_/\_\_\_
- New Hire  Status Change (PT to FT)
- Return from Leave/Layoff
- Birth  Marriage  Adoption (attach legal documentation)
- Court ordered dependent (attach documentation)
- Other (describe) \_\_\_\_\_
- COBRA/Continuation start date \_\_\_\_\_ stop date \_\_\_\_\_
- Annual Open Enrollment** Requested Effective Date of Enrollment \_\_\_/\_\_\_/\_\_\_

- Cancellations:** Last Date of Employment \_\_\_/\_\_\_/\_\_\_
- Requested Effective Date of Cancellation \_\_\_/\_\_\_/\_\_\_
- Cancel all coverage
- Cancel listed above – Section B
- Reason: (check one)
- Death  Employee Terminated  Divorce
- Moved out of service area
- Dependent reached student/dependent max age
- Other (describe) \_\_\_\_\_

Union  Non-union    
  Salaried  Hourly    
  Active  Retire Date \_\_\_\_\_

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

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