UnitedHealthcare®
A UnitedHealth Group Company

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

Group Name/Number

To Be Completed by Employer

☐ New ☐ Dependent Add/Delete ☐ Change Name/Address ☐ Cancel ☐ Date of Change

Group Specifics

Position/Title

Hours Worked

Plan Selected
Medical_____
Dental_____

Reason for Application
☐ New Group Plan
☐ Annual Open Enrollment
☐ New Hire
☐ Status Change _____
☐ Life event/date _____
☐ Other _____
☐ Date of Hire _____

Product Selection
Health ☐ Yes ☐ No
Life ☐ Yes ☐ No
$_____
Dep Life ☐ Yes ☐ No
Dental ☐ Yes ☐ No
Vision ☐ Yes ☐ No
Other _____

Employee Type
Active ☐ Yes ☐ No
COBRA./St Cont ☐ Yes ☐ No
Hourly ☐ Yes ☐ No
Salary ☐ Yes ☐ No
Union ☐ Yes ☐ No
Non-Union ☐ Yes ☐ No
Other _____

A. Employee Information

First Name	MI	Last Name	Social Security Number	Home Phone / Work Phone

Address	Apt #	City	State	Zip	Email Address

B. Family Information

List All Enrolling (Attach sheet if necessary) **Marital Status** ☐ Single ☐ Married

Last Name First Name MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time	Physician*(First and Last Name)
Employee	M F	Self				Student	
	M F	Spouse/[Dom. Partner]					
	M F					☐ Yes ☐ 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. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

C. Product Selection

(Please check all that apply)*

Person	Medical	Life	Sup Life	Sup AD&D	Dental	Vision	STD	LTD	Dual Option Plan Number
Employee		$	$	$					
Spouse		$							
Dependents		$							

*Benefit offerings are dependent upon employer election

Life Beneficiary's Full Name and Address

Relationship

D. Other Coverage Information

☐ Yes ☐ No	Has anyone on this application been covered with health benefits, including coverage with UnitedHealthcare within the past 2 years?	List dates covered	List all family members covered
☐ Yes ☐ No	Are you or any of your dependents covered by Medicare?	Reason ☐ Over 65 ☐ Disabled ☐ Kidney Disease	Covered by Part ☐ A ☐ B
If yes, Name of Medicare Beneficiary		Date Medicare became effective	Claim Number

E. Waiver of Coverage

I decline coverage for:
☐ Myself and all dependents
☐ Spouse
☐ Dependent Children (list names) _____

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 ☐ Other _____
☐ I (we) have no other coverage at this time

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Employee Initials	Date

F. Signature

I authorize United HealthCare Insurance Company/UnitedHealthcare of New England, Inc. and its affiliates ("The Company and Affiliates") 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 and Affiliates. I understand the purpose of the disclosure and use of my information is to allow The Company and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying The Company in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the 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.

(continued on back)

F. Signature (continued)

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents, I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance 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. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applicable)

G. Medical History

Employee Name _____ SSN _____ Group Name _____

Have you - or any person listed in section B ""Family Information"" on the front of this form - consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium.**

1A Cancer/Tumor ☐ Yes ☐ No	☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Other _____
1B Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Elevated Cholesterol/Triglycerides ☐ Heart Disease ☐ High Blood Pressure ☐ Phlebitis ☐ Skin Ulcer ☐ Stroke ☐ Varicose Veins ☐ Other_____
1C Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date___) ☐ Multiples Expected (#___) ☐ Pregnancy Complications (Current or Past) ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other _____
1D Intestinal/Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Gallbladder ☐ Hepatitis B/C ☐ Hiatal Hernia/Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Other _____
1E Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's Disease ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Other _____
1F Immune ☐ Yes ☐ No	☐ AIDS ☐ HIV+ ☐ Lupus ☐ Other_____
1G Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Chronic Bronchitis ☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea ☐ Other _____
1H Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Other_____
1I Urinary/Kidney ☐ Yes ☐ No	☐ Kidney Stones ☐ Neurogenic Bladder ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Other _____
1J Bones/Muscles ☐ Yes ☐ No	☐ Arthritis (Rheumatoid or Osteo) ☐ Bulging/Herniated Disc ☐ Joint injury ☐ Pituitary Dwarfism ☐ Pulled/Strained Muscle ☐ Spina Bifida ☐ Other Back/Neck Disorder ☐ Other _____
2 Mental Health/ Substance Abuse ☐ Yes ☐ No	☐ Alcoholism ☐ Anxiety/Depression ☐ Attention Deficit Disorder ☐ Bipolar/Manic Depression ☐ Drug Abuse ☐ Eating Disorder ☐ Suicide Attempt ☐ Other _____
3 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Discussed Possible Future Transplant ☐ Organ _____
4 Medication ☐ Yes ☐ No	☐ Current Medications ☐ Medications Taken Within The Past Year
5 Other ☐ Yes ☐ No	☐ Abnormal Test Or Physical Results ☐ Condition or Congenital Disorder Not Mentioned Above ☐ Treatment Or Surgery Discussed Or Advised, But Not Yet Done ☐ Unexplained Weight Change
6 Tobacco ☐ Yes ☐ No	☐ Anyone On This Application Used Tobacco Products In The Past 12 Months Name _____

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Prognosis

I authorize any required premium contributions to be deducted from earnings.

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance 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 the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

CONFIDENTIALITY

Make sure your employer has completed the "To be completed by the employer" section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.

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Your Rights and Responsibilities

Important Information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at **www.myuhc.com.**

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.
5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Pre-Existing Conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under state and/or federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 6 months (12 months for late entrants) from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under state and/or federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 90 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 90 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.