

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

Groups with 2 to 50 employees

Enrollment Application/Change/Cancellation Request for Medical Coverage

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

- Enroll, Cancel, Change, Address Change, Name Change, Date of Change

A. Employee Information

Form for Employee Information including fields for First Name, Last Name, Social Security #, Street Address, Home Phone, Work Phone, Marital Status, Sex, Birthdate, Height/Weight, Primary Language, and Physician information.

B. Family Information

Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary) Adding a dependent due to loss of other coverage requires a Certificate of Credible Coverage from the prior carrier.

Table for dependents with columns for Last Name, First Name, M.I., Sex, Birthdate, Relationship, Height/Weight, Physician, and Current Patient status.

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. If dependent does not reside with eligible employee, please provide address on separate sheet.

C. Product Selection (check all that apply)

Form for Product Selection with sections for Medical Benefits, Dental Benefits, Life Insurance Products, and Employer Use Only.

OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)

- UnitedHealthcare Overture Classic, UnitedHealthcare Overture Performance, UnitedHealthcare Overture Premier

D. To Be Completed By Employer

Form for Employer completion including Company Name, Group #, Plan Variation, Medical/Dental, Department Number, and enrollment/cancellation details.

Product Selections - Check all that apply

Form for Product Selections including UnitedHealthcare Choice+, Select+, Managed Indemnity, and Dental Plans.

Insurance products provided by United HealthCare Insurance Company +HMO coverage offered by UnitedHealthcare of Texas, Inc.

***Dental Benefits provided by Dental Benefit Providers, Inc., and affiliates

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information.

Signature/Employer Position, Date, Phone #

E. Other Medical Coverage Information / Waiver

(This section must be completed)

Applicant Name _____

Have you or your dependents had any other medical coverage in the last 12 months? YES NO Will this coverage be terminated? YES NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date
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Coverage type: Group Policy Individual Policy Medicare/Medicaid 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
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Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)
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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 #
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WAIVER I decline to enroll for this 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 must meet the requirements defined in the enrollment section of the Certificate of Coverage, and may apply at the 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 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth adoption, placement for adoption or party in suit of adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 31 days after such marriage, birth, adoption, placement for adoption or party in suit of 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)

F. Medical Research Studies / Additional Products & Services

- Please do not send me information regarding medical research studies.
- Please do not send me information regarding additional products and/or services.

Medical History (For Rating Purposes Only)

Have you or your dependents been diagnosed, treated, received counseling or advice during the past 5 years for any of the following:
PLEASE CHECK AND EXPLAIN ALL THAT APPLY.

Cancer/Tumor Lung Breast Liver Colon Leukemia/Lymphoma Melanoma
 Yes No **1** Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____ Stage/Level _____

Heart/Circulatory High Blood Pressure Stroke Aneurism Heart Disease Hemophilia Blood Disorder Skin Ulcer
 Yes No **2** Varicose Veins Phlebitis Congestive Heart Failure Bypass/Angioplasty
 Elevated Cholesterol/Triglycerides Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Reproductive Current Pregnancy (due date _____) Multiples expected _____ Pregnancy Complications (current or past)
 Yes No **3** Infertility Endometriosis Breast Disorders Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Intestinal/Endocrine Gallbladder Liver Disorder Hepatitis B/C Colon Disorder (provide diagnosis) Crohn's/Ulcerative Colitis
 Yes No **4** Diabetes Ulcer Chronic Pancreatitis Hiatal Hernia/Reflux Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Brain/Nervous Multiple Sclerosis Paralysis Cerebral Palsy Migraines Parkinson's Disease Alzheimer's Disease
 Yes No **5** Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Immune Lupus HIV+ AIDS Other _____
 Yes No **6** Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

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Lung/Respiratory Asthma Allergies Cystic Fibrosis Emphysema/Chronic Bronchitis
 Yes No **7** Pneumonia Tuberculosis Sleep Apnea Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

**Eyes/Ears/
Nose/Throat** Retinopathy Cleft lip/palate Chronic Sinusitis Deviated Septum Acoustic Neuroma Glaucoma
 Yes No **8** Cataracts Chronic Ear Infections Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Urinary/Kidney Renal Failure Polycystic Kidney Disease Neurogenic Bladder
 Yes No **9** Kidney Stones Prostate Disorder Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Bones/Muscles Bulging/Herniated Disc Pituitary Dwarfism Spina Bifida Arthritis (Rheumatoid or Osteo) Joint Injury
 Yes No **10** Pulled/Strained muscle Other back/neck disorders Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

**Mental Health/
Substance Abuse** Bipolar/Manic Depression Eating Disorder Anxiety/Depression Alcoholism Drug Abuse
 Yes No **11** Suicide Attempt Attention Deficit Disorder Other _____
 Patient Name _____ Date Diagnosed _____ Treatment _____
 Date Last Treated _____ Current Status _____

Transplant Organ _____ Bone Marrow Surgery Completed (Date _____) Discussed possible future transplant
 Yes No **12** Patient Name _____ Rejections/Complications _____
 Current Treatment _____
 (Date _____) Current Status _____

Medication Current Medications Patient Name _____
 Yes No **13** Medication Name _____
 Medications within the past year Member Name _____
 Medication Name _____ Date Last Taken _____

Other Treatment or surgery discussed or advised, but not yet done
 Yes No **14** Condition or Congenital Disorder not mentioned above
 Abnormal test or physical results Unexplained Weight Change
 Patient Name _____ Date _____
 Details _____

Yes No **15** Has anyone on this application used tobacco products in the past 12 months? Name _____

IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SHEET AND BE SURE TO DATE AND SIGN THAT SHEET.

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

IMPORTANT INFORMATION

In order to make choices about your health care 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 do not answer your questions.

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 may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.
4. 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.
5. 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.
6. 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 with you. If they do not, we encourage you to talk to your physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

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

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) 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 names 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 form. I (we) know that I (we) have the right to ask for and to 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 health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Medical Coverage. 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 Request for Medical Coverage and any attachments.