UnitedHealthcare®
A UnitedHealth Group Company

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

Groups with 2 to 9 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

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? | E-mail Address ☐ Home ☐ Work

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed | Sex ☐ M ☐ F | Birthdate | Height/Weight ____ft. ____in. ____lbs.

B. Family Information

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

Check appropriate box	Last Name First Name M.I. / Dependent Social Security No.	Sex	Birthdate	Relationship**	Height/ Weight	Full-Time Student
☐ Enroll ☐ Cancel ☐ Change	SS# | | | | – | | – | | | |	M F				☐ Yes ☐ No School Name:
☐ Enroll ☐ Cancel ☐ Change	SS# | | | | – | | – | | | |	M F				☐ Yes ☐ No School Name:
☐ Enroll ☐ Cancel ☐ Change	SS# | | | | – | | – | | | |	M F				☐ Yes ☐ No School Name:

***IMPORTANT: **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 separate sheet.**

C. Product Selection (check all that apply)

MEDICAL BENEFITS:
- ☐ Employee Only Coverage
- ☐ Employee/Spouse Coverage
- ☐ Employee/Children Coverage
- ☐ Employee/Spouse/Children Coverage
- ☐ **No Medical Coverage (complete Section E)**

DENTAL BENEFITS:
- ☐ Employee Only Coverage
- ☐ Employee/Spouse Coverage
- ☐ Employee/Children Coverage
- ☐ Employee/Spouse/Children Coverage
- ☐ No Dental Coverage

- ☐ I decline coverage for myself
- ☐ I decline coverage for my spouse
- ☐ I decline coverage for my child(ren)

Reason: ☐ Covered under another plan ☐ Other:_____

LIFE INSURANCE PRODUCTS

Salary $_____ ☐ wk ☐ mo ☐ yr

- ☐ Life/Accidental Death or Dismemberment
- ☐ Dependent Life Insurance

EMPLOYER USE ONLY

Benefit Level/Class Code

Life Beneficiary's Full Name and Address | Relationship

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

Company Name | Group # | Plan Variation | Medical _____ Dental _____ | Department Number | Date of Employment

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ (attach COBRA Election Form)
- ☐ 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 ☐ Retired/Date_____

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

Signature/Employer Position _____ Date _____ Phone # _____

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E. Other Medical Coverage Information / Waiver (This section must be completed)

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

Coverage type: ☐ Group Policy ☐ Individual Policy ☐ Medicare/Medicaid ☐ Other_____

Is this coverage through your spouse's employer? ☐ YES ☐ 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: ☐ Over 65 ☐ Disabled ☐ Kidney Disease	Medicare Claim #

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 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)

Medical History (applicable for groups of one to _____)

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 ☐ Yes ☐ No — 1
☐ Lung ☐ Breast ☐ Liver ☐ Colon ☐ Leukemia/Lymphoma ☐ Melanoma
☐ Other _____
Patient Name_____ Date Diagnosed _____ Treatment _____
Date Last Treated _____ Current Status _____ Stage/Level_____

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

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

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

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

Immune ☐ Yes ☐ No — 6
☐ Lupus ☐ HIV+ ☐ AIDS ☐ Other _____
Patient Name_____ Date Diagnosed _____ Treatment _____
Date Last Treated _____ Current Status _____

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Lung/Respiratory
□ Yes □ No

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□ Asthma □ Allergies □ Cystic Fibrosis □ Emphysema/Chronic Bronchitis
□ Pneumonia □ Tuberculosis □ Sleep Apnea □ Other _____
Patient Name_____ Date Diagnosed _____Treatment _____
Date Last Treated _____ Current Status _____

Eyes/Ears/ Nose/Throat
□ Yes □ No

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□ Retinopathy □ Cleft lip/palate □ Chronic Sinusitis □ Deviated Septum □ Acoustic Neuroma □ Glaucoma
□ Cataracts □ Chronic Ear Infections □ Other _____
Patient Name_____ Date Diagnosed _____Treatment _____
Date Last Treated _____ Current Status _____

Urinary/Kidney
□ Yes □ No

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□ Renal Failure □ Polycystic Kidney Disease □ Neurogenic Bladder
□ Kidney Stones □ Prostate Disorder □ Other_____
Patient Name_____ Date Diagnosed _____Treatment _____
Date Last Treated _____ Current Status _____

Bones/Muscles
□ Yes □ No

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□ Bulging/Herniated Disc □ Pituitary Dwarfism □ Spina Bifida □ Arthritis (Rheumatoid or Osteo) □ Joint Injury
□ Pulled/Strained muscle □ Other back/neck disorders Other _____
Patient Name_____ Date Diagnosed _____Treatment _____
Date Last Treated _____ Current Status _____

Mental Health/ Substance Abuse
□ Yes □ No

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□ Bipolar/Manic Depression □ Eating Disorder □ Anxiety/Depression □ Alcoholism □ Drug Abuse
□ Suicide Attempt □ Attention Deficit Disorder □ Other _____
Patient Name_____ Date Diagnosed _____Treatment _____
Date Last Treated _____ Current Status _____

Transplant
□ Yes □ No

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□ Organ_____ □ Bone Marrow □ Surgery Completed (Date _____) □ Discussed possible future transplant
Patient Name _____ Rejections/Complications _____
Current Treatment _____
(Date _____) Current Status _____

Medication
□ Yes □ No

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□ Current Medications Patient Name _____
Medication Name _____
□ Medications within the past year Patient Name _____
Medication Name _____ Date Last Taken_____

Other
□ Yes □ No

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□ Treatment or surgery discussed or advised, but not yet done
□ Condition or Congenital Disorder not mentioned above
□ Abnormal test or physical results □ Unexplained Weight Change
Patient Name _____ Date _____
Details _____

□ Yes □ No

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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.

I understand that submission of an application or filing a claim containing a false or deceptive statement, with intent to defraud or to facilitate a fraud against an insurer, constitutes insurance fraud.

Date _____ **Employee Signature** _____ **Spouse Signature** _____
(if possible) and applicable

OHIO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN OHIO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.

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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. Further information is available at www.uhc.com, at www.myuhc.com, at (800) 328-8835 – Columbus, (800) 468-5001 – Cleveland, (866) 351-6827 – Southwest Region, or through your employer contact.

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 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 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.

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.

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HMO products provided by UnitedHealthcare of Ohio, Inc.

Medical insurance and non-network benefits provided by United HealthCare Insurance Company of Ohio

Life insurance benefits provided by United HealthCare Insurance Company

***Dental Benefits provided by Dental Benefit Providers, Inc. and affiliates United HealthCare Insurance Company