Filing at a Glance

Company: Unimerica Life Insurance Company of New York

Product Name: 2010 AR Enrollment Application Forms

SERFF Tr Num: UHLC-126726595

State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-Closed

State Tr Num: 46234

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Ebony Terry

Disposition Date: 09/03/2010

Date Submitted: 07/19/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/03/2010

Deemer Date:

Submitted By: Ebony Terry

PPACA: Not PPACA-Related

Filing Description:

AR 2010 Enrollment Application Forms

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 09/03/2010

Created By: Ebony Terry

Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

800 King Farm Blvd.

Ebony_N_Terry@uhc.com

240-632-8053 [Phone]

Suite 500
Rockville, MD 20850

Filing Company Information

Unimerica Life Insurance Company of New York	CoCode: 11596	State of Domicile: New York
PO Box 150450	Group Code: 707	Company Type: Life and Health
Hartford, CT 06115-0450	Group Name:	State ID Number:
(860) 702-6017 ext. [Phone]	FEIN Number: 01-0637149	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Life Insurance Company of New York	$450.00	07/19/2010	38120598

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/03/2010	09/03/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Enrollment Form	Ebony Terry	08/19/2010	08/19/2010
Form	Enrollment Form	Ebony Terry	08/19/2010	08/19/2010
Supporting Document	Revised cover letter	Ebony Terry	08/19/2010	08/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010
Form	Enrollment Form	Ebony Terry	07/19/2010	07/19/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Revision	Note To Reviewer	Ebony Terry	07/29/2010	07/29/2010

Disposition

Disposition Date: 09/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126726595*	*State:*	*Arkansas*
Filing Company:	*Unimerica Life Insurance Company of New York*	*State Tracking Number:*	*46234*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 AR Enrollment Application Forms*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Revised cover letter	Approved-Closed	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Filed-Closed	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes

Amendment Letter

Submitted Date: 08/19/2010

Comments:

Please see cover

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
100-7381 6/10	Application/Enrollment Form	Enrollment Form	Initial					100-9866 health adden 10 8.12.10.pdf
100-5215 6/10	Application/Enrollment Form	Enrollment Form	Initial					100-9867 SB R_R broch 8 10.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Revised cover letter

Comment:

2010 Enrollment Form cover Letter _Revisions_.pdf

Note To Reviewer

Created By:
Ebony Terry on 07/29/2010 08:48 AM
Last Edited By:
Rosalind Minor
Submitted On:
09/03/2010 09:39 AM
Subject:
Revision
Comments:
Ms. Minor,

I hope you are well. I am writing you to request that you hold off on reviewing this filing. I recieved notice that a revision is to be made on the Rights and Responsibility Brochure form. The revised form has not been released to me yet but as soon as it is I will amend this filing. I just don't want you to have to review this form filing twice.

Thank you for your time

Amendment Letter

Submitted Date: 07/19/2010

Comments:

Ms. Minor,

I replaced seven of the enrollment forms because they were missing the company name, United Healthcare Insurance Company of the River Valley. All other content is the same.

Thank you

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SB.ER.10.AR 06/10	Application/Enrollment Form	Enrollment Form	Initial					SB ER 10 AR 6 10.pdf
SB.EESHT.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial					SB EESHT 10 AR 6 10.pdf
SB.EEONEQ.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial					
SB.EELNG.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial					SB EELNG 10 AR 6 10.pdf
SB.EE.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial					SB EE 10 AR 6 10 (2).pdf
LG.ER.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial					LG ER 10 AR 6 10.pdf
LG.EE.10.A	Application/E	Enrollment	Initial					LG EE 10 AR

R 7/10 nrollment Form Form 7 10.pdf

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/03/2010	SB.ER.10.AR 06/10	Application/Enrollment Form	Enrollment Form	Initial			SB ER 10 AR 6 10.pdf
Approved-Closed 09/03/2010	SB.EESHT.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial			SB EESHT 10 AR 6 10.pdf
Approved-Closed 09/03/2010	SB.EEONEQ.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial			
Approved-Closed 09/03/2010	SB.EELNG.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial			SB EELNG 10 AR 6 10.pdf
Approved-Closed 09/03/2010	SB.EE.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial			SB EE 10 AR 6 10 (2).pdf
Approved-Closed 09/03/2010	LG.ER.10.AR 6/10	Application/Enrollment Form	Enrollment Form	Initial			LG ER 10 AR 6 10.pdf
Approved-Closed 09/03/2010	LG.EE.10.AR 7/10	Application/Enrollment Form	Enrollment Form	Initial			LG EE 10 AR 7 10.pdf
Approved-Closed 09/03/2010	100-7381 6/10	Application/Enrollment Form	Enrollment Form	Initial			100-9866 health adden 10 8.12.10.pdf
Approved-Closed 09/03/2010	100-5215 6/10	Application/Enrollment Form	Enrollment Form	Initial			100-9867 SB R_R broch 8 10.pdf

(DO NOT STAPLE)

Employer Application for Small Business

[Groups with 2-99 Eligible Employees]

BAR CODE HERE

UnitedHealthcare
A UnitedHealth Group Company

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable)

Contact Person | Telephone | Fax | Email Address

Billing Address (If Different) | # of Years in Business

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other_____ | Nature of Business | Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No | # Locations | Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations. | Subject to ERISA regulation ☐ Yes ☐ No

Waiting Period for new hires
☐ 1st of Policy Month following Date of Hire
☐ 1st of Policy Month following ____ [months] [days] of employment
☐ Date of Hire (no waiting period)
☐ ____ [months] [days] of employment following Date of Hire

Waiting Period waived for initial enrollees ☐ Yes ☐ No

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

Have Workers' Comp ☐ Yes ☐ No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability: ☐ See Attached List ☐ None

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
# Hours per week to be eligible** _____		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company [or Unimerica Life Insurance Company of New York]
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy following a leave of absence? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Vision Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

Questions Regarding Group Size

☐ COBRA ☐ St. Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year. If your group had fewer than 20 employees during a calendar year, you must provide State Continuation effective January 1 of the next calendar year.
☐ Medicare Primary ☐ Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.
☐ Federally Compliant MH/SUD Benefits ☐ Not Required	Under federal law, if your group averaged 51 or more total employees (remember to include part-time and seasonal employees) during the preceding calendar year, you must provide employees with benefits compliant with federal mental health and substance use disorder parity laws and regulations (MH/SUD Parity Compliant Benefits), if your plan provides MH/SUD benefits. If your group had 50 or fewer employees, you are not required to provide MH/SUD Parity Compliant Benefits.
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Questions Regarding Group Size (continued)

☐ Yes ☐ No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

UnitedHealthcare disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers pursuant to federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date

Commission Information

Writing Broker Name	Writing Broker SSN		Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	**Broker Signature**	**Date**

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address

[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, 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.]

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and G.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?	Email Address
/ /	☐ M ☐ F			☐ Yes ☐ No	

Marital Status	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
___ – ___ – ___	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form. Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.** UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ Yes ☐ No 1. Is anyone on this application currently pregnant? If "yes" please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section.

☐ Yes ☐ No 2. Has anyone on this application visited any health care professional during the last 5 years for any illness, injury, or health condition? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ Yes ☐ No 3. Has anyone on this application been hospitalized (inpatient or outpatient) or had surgery in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ Yes ☐ No 4. Has anyone on this application been prescribed or taken any prescription medications in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ Yes ☐ No 5. Does anyone on this application have a health condition, illness, or injury that may require treatment or surgery, or has any health care professional recommended treatment or surgery for any of you that has not been performed? If your answer to either question is "yes" please provide detailed information below for each person involved.

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)

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

G. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

H. Signature

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

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

I. 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

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and G.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?	Email Address
/ /	☐ M ☐ F			☐ Yes ☐ No	

Marital Status	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
– –	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
– –	M F	Dependent					☐ Yes ☐ No
– –	M F	Dependent					☐ Yes ☐ No
– –	M F	Dependent					☐ Yes ☐ No
– –	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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. Medical History

Employee Name _____ SSN _____ Group Name _____

Has anyone on this application 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 retroactive to the date your policy became effective.** UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

1 Cancer ☐ Yes ☐ No	☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Other _____ ☐ Testicular ☐ Brain ☐ Ovarian ☐ Cervical ☐ Prostate Stage _____
2 Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Elevated Cholesterol/Triglycerides ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots ☐ Pacemaker ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ MI ☐ Other _____
3 Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date_____) ☐ Multiples (#___) ☐ Pregnancy Complications ☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other _____
4 Intestinal/Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis ☐ IBS ☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Other_____
5 Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's Disease ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Tumor ☐ Head Injury ☐ Cyst ☐ Other _____
6 Immune ☐ Yes ☐ No	☐ Scleroderma ☐ ALS ☐ Rheumatoid Arthritis ☐ Psoriasis ☐ AIDS ☐ HIV+ ☐ Lupus ☐ Immuno Deficiency ☐ Other _____
7 Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ COPD/Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis ☐ Sleep Apnea ☐ Other _____
8 Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Other_____
9 Urinary/Kidney ☐ Yes ☐ No	☐ Chronic Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Dialysis ☐ Other _____
10 Bones/Muscles ☐ Yes ☐ No	☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury ☐ Fibromyalgia/CFS ☐ Shoulder Disorder ☐ Knee Disorder ☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other _____
11 Behavioral Health ☐ Yes ☐ No	☐ Anxiety/Depression ☐ ADHD ☐ Bipolar/Manic Depression ☐ Schizophrenia ☐ Autism ☐ Eating Disorder ☐ Suicide Attempt ☐ Inpat ETOH/Drug ☐ Inpat MH Hosp ☐ Other _____
12 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Organ ☐ Stem Cell ☐ Discussed Possible Future Transplant ☐ Transplant Complications Year _____ ☐ Other _____
13 Rare Diseases ☐ Yes ☐ No	☐ Gaucher disease ☐ Fabry disease ☐ Enzyme Deficiency ☐ Metabolic disorder ☐ Phenylketonuria (PKU) ☐ Marfan Syndrome ☐ Other _____
14 Medication ☐ Yes ☐ No	☐ Current Medications Please List Meds_____ ☐ Medications Taken Within The Past Year Please List Meds _____
15 Other ☐ Yes ☐ No	☐ Abnormal Test Or Physical Results ☐ Condition Not Mentioned Above ☐ Treatment Or Surgery Discussed Or Advised ☐ Pending Test Results ☐ Inpat Hosp/Surg in Past Yr. ☐ Pending w/c claim ☐ Tests Advised or Recommended ☐ Refer to Specialist ☐ Disability

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	Current Meds	Physician's Name	Dates Treated	Prognosis

G. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

H. Signature

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

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

I. 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

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and F.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?	Email Address
/ /	☐ M ☐ F			☐ Yes ☐ No	

Marital Status	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
___ – ___ – ___	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

G. Signature

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

UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Please maintain a copy of this authorization for your records.

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

Insured Employer Application

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

General Information

Requested Effective Date _____

Group's/Company's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	
Billing Address (if different)				# of Years in Business

Multi-location group/company? ☐ Yes ☐ No	# of Locations	Address (es) (or list on additional sheet of paper)

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other _____	Nature of Business	Industry Code

Waiting Period for new hires	Waiting Period waived for initial enrollees	Medical Benefit Plan Option	ERISA Plan?
☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following ___ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ ____ [months] [days] of employment following Date of Hire ☐ Other _____	☐ Yes ☐ No	☐ Calendar Year ☐ Policy Year	☐ Yes ☐ No

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)	Number of Employees Termed in last 12 Months	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Name of Workers' Compensation Carrier	Names of Owners/Partners not covered by Workers' Compensation

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
		Basic Dep Life		Basic Dep Life		Basic Dep Life		
# Hours per week to be eligible** _____		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

☐ Yes ☐ No	In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy following a leave of absence?
(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
☐ Other (please provide a copy for our records)

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

HRA, HSA, Supplemental Insurance Information

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? ☐ Yes ☐ No

Who will provide account balances to UnitedHealthcare?

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Short-Term Disability Carrier	☐ None			
Current Long-Term Disability Carrier	☐ None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

☐ Yes ☐ No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

☐ Yes ☐ No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

☐ Yes ☐ No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

☐ Yes ☐ No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

☐ Yes ☐ No 6. Is any employee or dependent currently hospitalized?

☐ Yes ☐ No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?

- ☐ Cancer (any type)
- ☐ Lung disease or respiratory problem (any type)
- ☐ Heart disease or disorder (any type)
- ☐ Organ, tissue or cell transplant
- ☐ Liver disease (any type)
- ☐ Kidney disease (any type)
- ☐ Pancreatic disorder (any type)
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Morbid obesity
- ☐ Congenital abnormality
- ☐ Vascular disease (any type)
- ☐ Neurological disorder (any type)
- ☐ Immunological disorder (reportable types)
- ☐ Alcohol or drug addiction or abuse

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check One Employee	Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Current Treatment

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's employees.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature _____ **Date** _____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

Broker Name	Agency	Agent Code/Tax ID Number

Signature	Email Address	Social Security #	Phone Number	Date

Rep Name	Rep #

Commissions payable to	Broker Commission Schedule _____ Std Scale of _____ %

Enrollment Application/Change/Cancellation Request

UnitedHealthcare
A UnitedHealth Group Company

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____	Medical _____ Vision _____	Life/AD&D _____ Suppl. Life _____
Dental _____ Life _____	Dental _____ Life _____	Spouse Life _____ Suppl. AD&D _____

☐ **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
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State 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 all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

Employer Position_____ Phone Number_____

A. Employee Information

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

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth	Sex	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*
/ /	☐ M ☐ F		

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Race – Check all that apply (Optional)**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name First Name MI / Social Security Number	Sex	Relationship**	Birthdate	Physician*(First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Spouse		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)* ** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address	Relationship

D. 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	End Date	Name and date of birth of policyholder for other coverage
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

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.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

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 or 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. 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 for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

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, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or the at toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care 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 provider 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, and 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 provider'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 provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider 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 coverage.

I (we) request the indicated group 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 health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health 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 below. 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 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 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 Coverage and any attachments.

Health Addendum To Employer Application

For Rating Purposes

UnitedHealthcare
A UnitedHealth Group Company

Group Name:

Medical Profile (only for groups not requiring individual health statements)

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information. **Please provide details to "Yes" answers in the space provided. IMPORTANT:** Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No	1. Have any employees or dependents been diagnosed or treated during the past five years for: ☐ Cancer ☐ Immune Disorder ☐ Growth Hormones ☐ Tumor ☐ AIDS/HIV+ ☐ Transplants ☐ Heart/Circulatory ☐ Chronic Lung Disorder ☐ Hemophilia/Blood Disorders ☐ Stroke ☐ Kidney Disease/Failure ☐ Cerebral Palsy ☐ Reproductive Disorder ☐ Liver Disorders (Hepatitis) ☐ Sickle cell anemia ☐ Intestinal Disorder ☐ Back Disorder ☐ Immuno deficiency ☐ Endocrine Disorder ☐ Rheumatoid Arthritis ☐ Autism ☐ Diabetes ☐ Connective Tissue Disorder ☐ Brain/Nervous/Seizures ☐ Lupus ☐ Multiple Sclerosis ☐ Other Conditions _____
☐ Yes ☐ No	2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section.
☐ Yes ☐ No	3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years?
☐ Yes ☐ No	4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?
☐ Yes ☐ No	5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?
☐ Yes ☐ No	6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare?

If you answered "Yes" to any of the questions above, please provide the requested information for each individual.
If necessary, continue your comments on the back side of this form.

Question #	Check One Emp	Check One Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by UnitedHealthcare Insurance Company and its Affiliates ("UnitedHealthcare and Affiliates").

The Group shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent, including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent that, to the best of my knowledge, the information I have provided in this application - including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws - is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy effective date, or other consequences.

Signature

Group Signature	Title	Date

By completing your enrollment form:

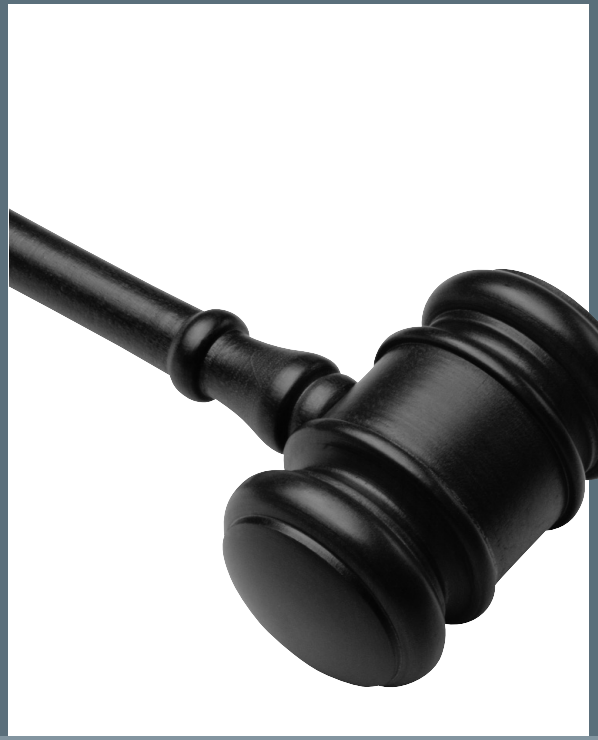
- You authorize all providers of health services or supplies and any of their representatives to give the following to UnitedHealthcare: any available information about the medical history, condition or treatment of any person named in the request. You authorize UnitedHealthcare to use the information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.
- You also authorize UnitedHealthcare to give the information to its (their) representatives or to any other organization for the reason noted above. You agree that the authorization is valid for 30 months from the date of the enrollment form. You have the right to ask for and receive a copy of the authorization.
- You understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding your coverage may be transmitted electronically.
- You have not given the agent or any other persons any health information not included on the enrollment form. You understand that UnitedHealthcare is not bound by any statements you have made to any agent or to any other persons, if those statements are not written or printed on the enrollment form and any attachments.
- You have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after you sign the enrollment form and before receipt of your 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.

UnitedHealthcare®

100-9867 8/10 ©2010 United HealthCare Services, Inc.



Your rights and responsibilities

UnitedHealthcare®

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 **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.

Preexisting 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 preexisting condition.

Under 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 preexisting condition exists. A group health plan may exclude benefits for preexisting conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a preexisting condition. A preexisting 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 preexisting condition unless there is a specific diagnosis related to the information.

Any references to Preexisting Conditions do not apply to anyone under the age of 19 whose plan is subject to insurance reforms contained in the Affordable Care Act.

Under federal law, a group health plan must reduce a preexisting 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 63 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 preexisting condition exclusion period. In determining whether there has been a break in coverage of 63 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 preexisting condition exclusion), you must show proof of prior coverage. You have the right to request a certificate of creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information. If you have questions regarding the preexisting condition limitation or certificate of creditable coverage, please contact Customer Care at 1-800-357-0978.

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

When completing a joint life and health enrollment form, you must understand that each response must be complete and accurate.

You request the indicated group medical and/or life coverages for yourself and, if the plan provides, for your dependents.

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

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/03/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/03/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/03/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/03/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/03/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter	Approved-Closed	09/03/2010

Comments:

Attachment:

2010 Enrollment Form cover Letter.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Revised cover letter	Approved-Closed	09/03/2010

Comments:

Attachment:

2010 Enrollment Form cover Letter _Revisions_.pdf

UnitedHealthcare®
A UnitedHealth Group Company

July 18, 2010

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: [UnitedHealthcare Insurance Company
NAIC No. 79413
Unimerica Insurance Company
NAIC No. 91529]
[95446 United Healthcare of Arkansas, Inc.®]
Enrollment/Application Filings

Dear Ms. Minor,

On behalf of [UnitedHealthcare Insurance Company] [Unimerica Insurance Company] [United Healthcare of Arkansas, Inc.®] I am submitting the enclosed enrollment/application forms for your Department's review and approval. A listing and description of the forms, along with the Flesch Scores, has been provided below for your reference.

Form Number	Description	Flesch Score
SB.ER.10.AR 06/10	Employer Application	40.1
SB.EE.10.AR 6/10	Employee Application (no medical questions)	40.5
SB.EESHT.10.AR 6/10	Employee Application (short version)	46.5
SB.EELNG.10.AR 6/10	Employee Application (long version)	41.8
SB.EEONEQ.10.AR 6/10	Employee Application (one medical question)	46.5
LG.ER.10.AR 6/10	Employer Application	50.2
LG.EE.10.AR 7/10	Employee Application	52.5
100-5215 6/10	Rights and Responsibilities Brochure	43.5
100-7381 6/10	Health Addendum	41.1

These forms are our standard forms and have been prepared for use in your state for group sizes 2-99 for medical, dental, vision and ancillary products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Ebony N. Terry
Compliance Analyst

UnitedHealthcare®
A UnitedHealth Group Company

August 18, 2010

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: [UnitedHealthcare Insurance Company
NAIC No. 79413
Unimerica Insurance Company
NAIC No. 91529]
[95446 United Healthcare of Arkansas, Inc.®]
Enrollment/Application Filings

Dear Ms. Minor,

On behalf of [UnitedHealthcare Insurance Company] [Unimerica Insurance Company] [United Healthcare of Arkansas, Inc.®] I am submitting the enclosed replacement enrollment/application forms for your Department's review and approval. A listing and description of the forms, along with the Flesch Scores, has been provided below for your reference.

Form Number	Description	Flesch Score
100-9866 8/10	**Rights and Responsibilities Brochure**	**43.5**
100-7381 8/10	**Health Addendum**	**41.1**

These forms are our standard forms and have been prepared for use in your state for group sizes 2-99 for medical, dental, vision and ancillary products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

The revisions to these replacement forms are clerical for the most part but If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Ebony N. Terry
Compliance Analyst

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/18/2010	Form	Enrollment Form	07/19/2010	SB ER 10 AR 6 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	07/19/2010	SB EESHT 10 AR 6 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	07/19/2010	SB EEONEQ 10 AR 6 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	07/19/2010	SB EELNG 10 AR 6 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	07/19/2010	SB EE 10 AR 6 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	07/19/2010	LG ER 10 AR 6 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	07/19/2010	LG EE 10 AR 7 10.pdf (Superceded)
07/18/2010	Form	Enrollment Form	08/19/2010	100-7381 health adden 10_final.pdf (Superceded)
07/18/2010	Form	Enrollment Form	08/19/2010	100-5215 SB R_R broch 6 10 FINAL.pdf (Superceded)

(DO NOT STAPLE)

Employer Application for Small Business

[Groups with 2-99 Eligible Employees]

BAR CODE HERE

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable)

Contact Person | Telephone | Fax | Email Address

Billing Address (If Different) | # of Years in Business

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other_____ | Nature of Business | Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No | # Locations | Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations. | Subject to ERISA regulation ☐ Yes ☐ No

Waiting Period for new hires
☐ 1st of Policy Month following Date of Hire
☐ 1st of Policy Month following ____ [months] [days] of employment
☐ Date of Hire (no waiting period)
☐ ____ [months] [days] of employment following Date of Hire

Waiting Period waived for initial enrollees ☐ Yes ☐ No

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

Have Workers' Comp ☐ Yes ☐ No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability: ☐ See Attached List ☐ None

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
# Hours per week to be eligible** _____		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company [or Unimerica Life Insurance Company of New York]
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy following a leave of absence? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Vision Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

Questions Regarding Group Size

☐ COBRA ☐ St. Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year. If your group had fewer than 20 employees during a calendar year, you must provide State Continuation effective January 1 of the next calendar year.
☐ Medicare Primary ☐ Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.
☐ Federally Compliant MH/SUD Benefits ☐ Not Required	Under federal law, if your group averaged 51 or more total employees (remember to include part-time and seasonal employees) during the preceding calendar year, you must provide employees with benefits compliant with federal mental health and substance use disorder parity laws and regulations (MH/SUD Parity Compliant Benefits), if your plan provides MH/SUD benefits. If your group had 50 or fewer employees, you are not required to provide MH/SUD Parity Compliant Benefits.
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Questions Regarding Group Size (continued)

☐ Yes ☐ No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

UnitedHealthcare disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers pursuant to federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date

Commission Information

Writing Broker Name	Writing Broker SSN		Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	**Broker Signature**	**Date**

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address

[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, 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.]

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and G.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth / /	Sex ☐ M ☐ F	Height	Weight	Used tobacco in the last 12 months? ☐ Yes ☐ No	Email Address

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
___ – ___ – ___	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No
___ – ___ – ___	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form. Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.** UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ Yes ☐ No 1. Is anyone on this application currently pregnant? If "yes" please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section.

☐ Yes ☐ No 2. Has anyone on this application visited any health care professional during the last 5 years for any illness, injury, or health condition? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ Yes ☐ No 3. Has anyone on this application been hospitalized (inpatient or outpatient) or had surgery in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ Yes ☐ No 4. Has anyone on this application been prescribed or taken any prescription medications in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ Yes ☐ No 5. Does anyone on this application have a health condition, illness, or injury that may require treatment or surgery, or has any health care professional recommended treatment or surgery for any of you that has not been performed? If your answer to either question is "yes" please provide detailed information below for each person involved.

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)

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

G. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

H. Signature

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

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

I. 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

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and G.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?	Email Address
/ /	☐ M ☐ F			☐ Yes ☐ No	

Marital Status	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
_ _ _	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form. Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.** UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ Yes ☐ No In the last 5 years have you or any member of your family listed on this application been diagnosed or treated by a licensed medical provider for cancer, diabetes, multiple sclerosis, mental/nervous disorders, congenital birth defects or diseases, organ or other transplants, hemophilia, HIV/AIDS, immune disorders, bone/joint disorders, diseases of the liver, kidney, lungs, heart/circulatory system; or is anyone currently pregnant, incurred medical / pharmacy claims in excess of $5,000 or currently undergoing treatment / receiving care for a medical condition not listed above?

Please give details to any "yes" answer above.
(If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)

Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

G. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

H. Signature

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

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

I. 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

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and G.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?	Email Address
/ /	☐ M ☐ F			☐ Yes ☐ No	

Marital Status	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
_ _	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No
_ _	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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. Medical History

Employee Name _____ SSN _____ Group Name _____

Has anyone on this application 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 retroactive to the date your policy became effective.** UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

1 Cancer ☐ Yes ☐ No	☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Other _____ ☐ Testicular ☐ Brain ☐ Ovarian ☐ Cervical ☐ Prostate Stage _____
2 Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Elevated Cholesterol/Triglycerides ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots ☐ Pacemaker ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ MI ☐ Other _____
3 Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date_____) ☐ Multiples (#___) ☐ Pregnancy Complications ☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other _____
4 Intestinal/Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis ☐ IBS ☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Other_____
5 Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's Disease ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Tumor ☐ Head Injury ☐ Cyst ☐ Other _____
6 Immune ☐ Yes ☐ No	☐ Scleroderma ☐ ALS ☐ Rheumatoid Arthritis ☐ Psoriasis ☐ AIDS ☐ HIV+ ☐ Lupus ☐ Immuno Deficiency ☐ Other _____
7 Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ COPD/Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis ☐ Sleep Apnea ☐ Other _____
8 Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Other_____
9 Urinary/Kidney ☐ Yes ☐ No	☐ Chronic Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Dialysis ☐ Other _____
10 Bones/Muscles ☐ Yes ☐ No	☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury ☐ Fibromyalgia/CFS ☐ Shoulder Disorder ☐ Knee Disorder ☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other _____
11 Behavioral Health ☐ Yes ☐ No	☐ Anxiety/Depression ☐ ADHD ☐ Bipolar/Manic Depression ☐ Schizophrenia ☐ Autism ☐ Eating Disorder ☐ Suicide Attempt ☐ Inpat ETOH/Drug ☐ Inpat MH Hosp ☐ Other _____
12 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Organ ☐ Stem Cell ☐ Discussed Possible Future Transplant ☐ Transplant Complications Year _____ ☐ Other _____
13 Rare Diseases ☐ Yes ☐ No	☐ Gaucher disease ☐ Fabry disease ☐ Enzyme Deficiency ☐ Metabolic disorder ☐ Phenylketonuria (PKU) ☐ Marfan Syndrome ☐ Other _____
14 Medication ☐ Yes ☐ No	☐ Current Medications Please List Meds_____ ☐ Medications Taken Within The Past Year Please List Meds _____
15 Other ☐ Yes ☐ No	☐ Abnormal Test Or Physical Results ☐ Condition Not Mentioned Above ☐ Treatment Or Surgery Discussed Or Advised ☐ Pending Test Results ☐ Inpat Hosp/Surg in Past Yr. ☐ Pending w/c claim ☐ Tests Advised or Recommended ☐ Refer to Specialist ☐ Disability

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	Current Meds	Physician's Name	Dates Treated	Prognosis

G. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

H. Signature

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

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

I. 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

(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Employee Enrollment Form

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 / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date_____
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee

Employee Type
(Check all that apply)
- ☐ Active
- ☐ COBRA ☐ State Continuation
  Start dt ____/____/____
  End dt____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and F.

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

Address	Apt #	City	State	Zip Code	Language preference, if not English

Date of Birth	Sex	Height	Weight	Used tobacco in the last 12 months?	Email Address
/ /	☐ M ☐ F			☐ Yes ☐ No	

Marital Status	Physician* (First & Last Name)/ ID #	Primary Care Dentist** (First & Last Name)/ ID #
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#) Primary Care Dentist** (Name/ID#)	Tobacco Used
_ _ _	M F	Spouse [/Domestic Partner]					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No
_ _ _	M F	Dependent					☐ Yes ☐ No

*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents. **Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. ***For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name _____

C. Product Selection

Please check the box for each coverage you or your dependents are enrolling in.
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	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse [Domestic Partner]	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	STD Buy Up	LTD	LTD Buy Up
Employee	☐ $_____	☐ $_____	☐ $_____	☐ $_____

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

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

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date	Employee Signature if waiving coverage

G. Signature

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

UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Please maintain a copy of this authorization for your records.

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 or insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

Insured Employer Application

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

General Information

Requested Effective Date _____

Group's/Company's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	
Billing Address (if different)			# of Years in Business	

Multi-location group/company? ☐ Yes ☐ No	# of Locations	Address (es) (or list on additional sheet of paper)

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other _____	Nature of Business	Industry Code

Waiting Period for new hires	Waiting Period waived for initial enrollees	Medical Benefit Plan Option	ERISA Plan?
☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following ___ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ ____ [months] [days] of employment following Date of Hire ☐ Other _____	☐ Yes ☐ No	☐ Calendar Year ☐ Policy Year	☐ Yes ☐ No

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)	Number of Employees Termed in last 12 Months	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Name of Workers' Compensation Carrier	Names of Owners/Partners not covered by Workers' Compensation

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
		Basic Dep Life		Basic Dep Life		Basic Dep Life		
# Hours per week to be eligible** _____		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

☐ Yes ☐ No	In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy following a leave of absence?
(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
☐ Other (please provide a copy for our records)

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

HRA, HSA, Supplemental Insurance Information

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? ☐ Yes ☐ No

Who will provide account balances to UnitedHealthcare?

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Short-Term Disability Carrier	☐ None			
Current Long-Term Disability Carrier	☐ None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

☐ Yes ☐ No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

☐ Yes ☐ No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

☐ Yes ☐ No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

☐ Yes ☐ No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

☐ Yes ☐ No 6. Is any employee or dependent currently hospitalized?

☐ Yes ☐ No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?

- ☐ Cancer (any type)
- ☐ Lung disease or respiratory problem (any type)
- ☐ Heart disease or disorder (any type)
- ☐ Organ, tissue or cell transplant
- ☐ Liver disease (any type)
- ☐ Kidney disease (any type)
- ☐ Pancreatic disorder (any type)
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Morbid obesity
- ☐ Congenital abnormality
- ☐ Vascular disease (any type)
- ☐ Neurological disorder (any type)
- ☐ Immunological disorder (reportable types)
- ☐ Alcohol or drug addiction or abuse

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check One Employee	Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Current Treatment

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's employees.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature _____ **Date** _____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

Broker Name	Agency	Agent Code/Tax ID Number

Signature	Email Address	Social Security #	Phone Number	Date

Rep Name	Rep #

Commissions payable to	Broker Commission Schedule _____ Std Scale of _____ %

Enrollment Application/Change/Cancellation Request

UnitedHealthcare
A UnitedHealth Group Company

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____	Medical _____ Vision _____	Life/AD&D _____ Suppl. Life _____
Dental _____ Life _____	Dental _____ Life _____	Spouse Life _____ Suppl. AD&D _____

☐ **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
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State 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 all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

Employer Position_____ Phone Number_____

A. Employee Information

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

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth	Sex	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*
/ /	☐ M ☐ F		

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Race – Check all that apply (Optional)**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name First Name MI / Social Security Number	Sex	Relationship**	Birthdate	Physician*(First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Spouse		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)* ** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address	Relationship

D. 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	End Date	Name and date of birth of policyholder for other coverage
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

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.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

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

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 acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

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 or 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. 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 for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

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, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or the at toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care 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 provider 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, and 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 provider'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 provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider 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 coverage.

I (we) request the indicated group 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 health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health 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 below. 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 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 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 Coverage and any attachments.

Health Addendum To Employer Application

For Rating Purposes

UnitedHealthcare
A UnitedHealth Group Company

Group Name:

Medical Profile (only for groups not requiring individual health statements)

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information. **Please provide details to "Yes" answers in the space provided. IMPORTANT:** Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No	1. Have any employees or dependents been diagnosed or treated during the past five years for: ☐ Cancer ☐ Immune Disorder ☐ Growth Hormones ☐ Tumor ☐ AIDS/HIV+ ☐ Transplants ☐ Heart/Circulatory ☐ Chronic Lung Disorder ☐ Hemophilia/Blood Disorders ☐ Stroke ☐ Kidney Disease/Failure ☐ Cerebral Palsy ☐ Reproductive Disorder ☐ Liver Disorders (Hepatitis) ☐ Sickle cell anemia ☐ Intestinal Disorder ☐ Back Disorder ☐ Immuno deficiency ☐ Endocrine Disorder ☐ Rheumatoid Arthritis ☐ Autism ☐ Diabetes ☐ Connective Tissue Disorder ☐ Brain/Nervous/Seizures ☐ Lupus ☐ Multiple Sclerosis ☐ Other Conditions _____
☐ Yes ☐ No	2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section.
☐ Yes ☐ No	3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years?
☐ Yes ☐ No	4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?
☐ Yes ☐ No	5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?
☐ Yes ☐ No	6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare?

If you answered "Yes" to any of the questions above, please provide the requested information for each individual.
If necessary, continue your comments on the back side of this form.

Question #	Check One Emp	Check One Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by UnitedHealthcare Insurance Company and its Affiliates ("UnitedHealthcare and Affiliates").

The Group shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent, including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent that, to the best of my knowledge, the information I have provided in this application - including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws - is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy effective date, or other consequences.

Signature

Group Signature	Title	Date

FINAL DRAFT

By completing your enrollment form:

- You authorize all providers of health services or supplies and any of their representatives to give the following to UnitedHealthcare: any available information about the medical history, condition or treatment of any person named in the request. You authorize UnitedHealthcare to use the information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.
- You also authorize UnitedHealthcare to give the information to its (their) representatives or to any other organization for the reason noted above. You agree that the authorization is valid for 30 months from the date of the enrollment form. You have the right to ask for and receive a copy of the authorization.
- You understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding your coverage may be transmitted electronically.
- You have not given the agent or any other persons any health information not included on the enrollment form. You understand that UnitedHealthcare is not bound by any statements you have made to any agent or to any other persons, if those statements are not written or printed on the enrollment form and any attachments.
- You have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after you sign the enrollment form and before receipt of your 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.

UnitedHealthcare®

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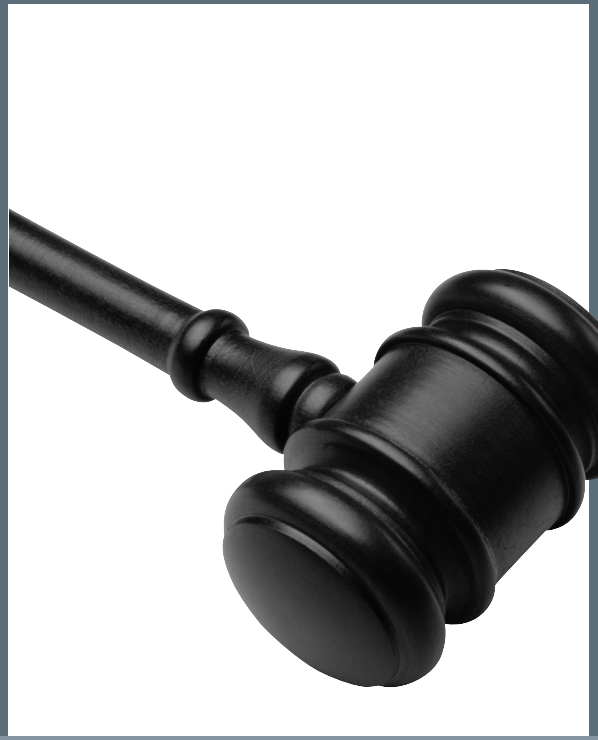

Your rights and responsibilities

UnitedHealthcare®

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 **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.

Preexisting 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 preexisting condition.

Under 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 preexisting condition exists. A group health plan may exclude benefits for preexisting conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a preexisting condition. A preexisting 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 preexisting condition unless there is a specific diagnosis related to the information.

Any references to Preexisting Conditions do not apply to anyone under the age of 19 whose plan is subject to insurance reforms contained in the Affordable Care Act.

Under federal law, a group health plan must reduce a preexisting 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 63 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 preexisting condition exclusion period. In determining whether there has been a break in coverage of 63 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 preexisting condition exclusion), you must show proof of prior coverage. You have the right to request a certificate of creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information. If you have questions regarding the preexisting condition limitation or certificate of creditable coverage, please contact Customer Care at 1-800-357-0978.

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

When completing a joint life and health enrollment form, you must understand that each response must be complete and accurate.

You request the indicated group medical and/or life coverages for yourself and, if the plan provides, for your dependents.

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