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

☐ **Enroll** ☐ **Cancel** ☐ **Change** | ☐ **Address Change** ☐ **Name Change** **Date of Change**____ /___ /____

A. Employee Information

First Name	M.I.	Last Name	Social Security #/Employee ID #

Street Address	Apt. #	City	County	State	Zip	Country

Home Phone	Work Phone	How many hours do you work per week?	E-mail Address ☐ Home ☐ Work

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Sex ☐ M ☐ F	Birthdate	Physician*	Physician's ID No.	Are you a current patient? ☐ Yes ☐ No

B. Family Information

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

Check appropriate box	Last Name / First Name / M.I. / Dependent Social Security No.	Sex	Birthdate	Relationship**	Full-Time Student	Physician* / Physician's ID Number	Are you a Current Patient?
☐ Enroll ☐ Cancel ☐ Change	SS# | | | – | | – | | | |	M F			☐ Yes ☐ No School Name:		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | – | | – | | | |	M F			☐ Yes ☐ No School Name:		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | – | | – | | | |	M F			☐ Yes ☐ No School Name:		☐ YES ☐ NO

***IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care), for yourself and each of your covered dependents for UnitedHealthcare Select and Select Plus only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.**

C. Product Selection (check all that apply)

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

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

- ☐ I decline coverage for myself
- ☐ I decline coverage for my spouse
- ☐ I decline coverage for my children

Reason: ☐ Covered under another plan ☐ Other:________________________________

OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)
☐ UnitedHealthcare Overture Classic ☐ UnitedHealthcare Overture Performance ☐ UnitedHealthcare Overture Premier

D. To Be Completed By Employer

Company Name	Group #	Plan Variation Medical ______ Dental ______	Report Code	Date of Employment

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ Requested Date of Coverage ___ /___ /___
- ☐ New Hire ☐ Status Change (PT to FT)
- ☐ Return from Leave/Layoff
- ☐ Birth ☐ Marriage ☐ Adoption (attach legal documentation)
- ☐ Court ordered dependent (attach documentation)
- ☐ Other (describe) ______________________

(attach COBRA Election Form)

☐ COBRA/Continuation start date _______ stop date________
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___ /___ /___

☐ **Cancellations:** Last Date of Employment ___ /___ /___
Requested Effective Date of Cancellation ___ /___ /___
- ☐ Cancel all coverage
- ☐ Cancel listed above – Section B

Reason: (check one)
- ☐ Death ☐ Employee Terminated ☐ Divorce
- ☐ Moved out of service area
- ☐ Dependent reached student/dependent max age
- ☐ Other (describe)______________________________

Product Selections – Check all that apply ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retired/Date______

- ☐ UnitedHealthcare Choice Plus
- ☐ UnitedHealthcare Managed Indemnity
- ☐ UnitedHealthcare Select Plus HMO
- ☐ Individual Policy
- ☐ UnitedHealthcare Select HMO
- ☐ UnitedHealthcare Options PPO
- ☐ UnitedHealthcare Options PPO 80/80
- ☐ UnitedHealthcare Overture Package ______ (A-S)

DENTAL PLANS
- ☐ UnitedHealthcare Dental Managed Indemnity
- ☐ UnitedHealthcare Dental Options PPO

Healthy New York ☐ Individual ☐ Sole Proprietor ☐ Small Business Employee

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

Signature ______________________________________ Date ____________________

Employer Position______________________________ Phone Number____________________

Grp/Subgrp/Bnft Grp
Plan Variation
Reporting Code/Branch

Applicant Name ________________________

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

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

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date ___________

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

Is this coverage through your spouse's employer? ☐ YES ☐ NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)

Medicare effective date Parts A&B	Reason for Medicare eligibility: ☐ Over 65 ☐ Disabled ☐ Kidney Disease	Medicare Claim #

WAIVER **I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:**

☐ Existence of other health coverage ☐ Spousal coverage ☐ Other Reason (Explain) ________________________________

Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information"located on the back of this form.

X Employee Signature____ Date Signed________________________

(only sign if you are waiving coverage)

F. Medical Research Studies / Additional Products & Services

☐ **Please do not send me information regarding medical research studies.**

☐ **Please do not send me information regarding additional products and/or services.**

Signature (Form must be signed)

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

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date ___________ **Employee Signature** ________________________________ **Spouse Signature** ________________________

(if possible) and applicable

NEW YORK INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN NEW YORK 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. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.