

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

Groups with 2 to 50 employees

Enrollment Application/Change/Cancellation Request for Medical Coverage

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

- Enroll Address Change
 Cancel Name Change
 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 <input type="checkbox"/> Home <input type="checkbox"/> Work		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Physician*		Physician's ID No.	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

B. Family Information

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

Check appropriate box	Last Name	First Name	M.I.	Sex	Birthdate	Relationship**	Full-Time Student	Physician*	Are you a Current Patient?
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Dependent Social Security No.			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	Physician's ID Number	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS#			M F			<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Employee Only Coverage <input type="checkbox"/> Employee/Spouse Coverage <input type="checkbox"/> Employee/Children Coverage <input type="checkbox"/> Employee/Spouse/Children Coverage <input type="checkbox"/> No Medical Coverage (complete Section E)	DENTAL BENEFITS: <input type="checkbox"/> Employee Only Coverage <input type="checkbox"/> Employee/Spouse Coverage <input type="checkbox"/> Employee/Children Coverage <input type="checkbox"/> Employee/Spouse/Children Coverage <input type="checkbox"/> No Dental Coverage	<input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my spouse <input type="checkbox"/> I decline coverage for my children Reason: <input type="checkbox"/> Covered under another plan <input type="checkbox"/> Other: _____
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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
<input type="checkbox"/> New Enrollment/Additions: (Check one) Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ (attach COBRA Election Form) <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Court ordered dependent (attach documentation) <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___/___/___		<input type="checkbox"/> Cancellations: Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel listed above – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____			
Product Selections – Check all that apply					
<input type="checkbox"/> UnitedHealthcare Choice Plus <input type="checkbox"/> UnitedHealthcare Managed Indemnity <input type="checkbox"/> UnitedHealthcare Select Plus HMO <input type="checkbox"/> Individual Policy Healthy New York <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Small Business Employee		<input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Active <input type="checkbox"/> Retired/Date _____		DENTAL PLANS <input type="checkbox"/> UnitedHealthcare Dental Managed Indemnity <input type="checkbox"/> UnitedHealthcare Dental Options PPO <input type="checkbox"/> UnitedHealthcare Overture Package (A-S)	

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

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

Applicant Name _____

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

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

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.

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials do not answer your questions. Further information is available at 1-800-705-1691.

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

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

I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents, I authorize any required premium contributions to be deducted from earnings.

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

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date 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 or Summary Plan Description and other documents, notices and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Medical Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Medical Coverage and any attachments.

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

Group Medical Insurance provided by or through:
UnitedHealthcare of New York, Inc.
UnitedHealthcare of Upstate New York, Inc.
United HealthCare Insurance Company of New York