

Enrollment Application and Change Form

PLEASE READ INSTRUCTIONS ON REVERSE SIDE.

New Coverage Request for Change

EMPLOYEE INFORMATION

| | | | | | | |
|---------------|-------------------|------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------|
| Last Name | First Name | MI | Sex | Date of Birth | Social Security Number | Marital Status |
| | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | <input type="checkbox"/> Single <input type="checkbox"/> Married |
| Home Address | City | State | Zip Code | Home Phone Number | Work Phone Number | |
| Employer Name | Division/Location | <input type="checkbox"/> FT <input type="checkbox"/> PT | <input type="checkbox"/> Union <input type="checkbox"/> Nonunion | <input type="checkbox"/> Hourly <input type="checkbox"/> Salary | <input type="checkbox"/> Active <input type="checkbox"/> Retired (Date _____) | |

2 TYPE OF MEDICAL COVERAGE

Select Plus/POS (1) Options/PPO (4)
 Select/EPO (2) Managed Indemnity (5)
 Choice Plus/Open Access (3) Indemnity Plan (6)

**Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.*

Reason: I decline coverage for myself
 I decline coverage for my dependents
 covered under another plan
 Other: _____

3 WHO SHOULD BE COVERED

Employee Only
 Employee Plus Spouse
 Employee Plus One Dependent
 Employee Plus Child(ren)
 Employee Plus Family

4 TYPE OF CHANGE

Add Spouse/Child (complete Sec. 5) Reinstatement – Reason _____
 Terminate Spouse/Child (complete Sec. 5)
 Address (enter above)
 Name Change (complete Sec. 5)
 Terminate All Coverage – Reason _____
 COBRA Continuee – Former Employee SSN _____
 Other _____

5 COVERAGE INFORMATION

| (A) Add (T) Term (C) Orig | Last Name | First Name | MI | Zip Code | Date of Birth (MM/DD/YYYY) | Sex | Other Medical Insurance | Disabled | Full-Time Student Over 18? |
|---------------------------|-----------|------------|----|----------|----------------------------|-----|-------------------------|----------|----------------------------|
| | Employee | | | | | | | | |
| | Spouse | | | | | | | | |
| | Child 1 | | | | | | | | |
| | Child 2 | | | | | | | | |
| | Child 3 | | | | | | | | |

6 PRIMARY CARE PHYSICIAN INFORMATION

REQUIRED FOR SELECT PLUS/POS AND SELECT/EPO NETWORK PROVIDER PLANS

| Primary Care Physician (From Directory) | PCP Zipcode | Existing Patient | 13-Digit PCP ID Number (from Directory) |
|-----------------------------------------|-------------|----------------------------------------------------------|-----------------------------------------|
| | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | | <input type="checkbox"/> Y <input type="checkbox"/> N | |

7 OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other Medical Health plan or policy including another United Healthcare plan or Medicaer? _____ Y N

Is another person legally responsible for coverage for your child(ren)? _____ Y N

If you answered yes to either of the questions above, please complete the following:

Person's Name with Other Health Plan _____ Social Security Number _____

8 AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this form ("US"), I authorize any health care professional or entity to give United Healthcare and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to US for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of US the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents coverage. I further understand that coverage will become effective only on the date specified by the insurer or Plan Administrator after it has been approved by the insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employees plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.

NOTICE OF ENROLLMENT RIGHTS

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. 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Health insurance or medical services benefits provided or administered by United Healthcare Insurance Company, Minneapolis, MN.

X Signature _____ Date _____

9 TO BE COMPLETED BY EMPLOYER

| | | | |
|--------------------------------------------------|---------------------------------------|-------------------------|---------------|
| Date of Hire | Date Submitted | Health/Change Eff. Date | Policy Number |
| | | | |
| Medicare Number | Part A Effective Date | Part B Effective Date | |
| | | | |
| Date of Birth | | | |
| Sex | Other Company's Name and Phone Number | | |
| | | | |
| Other Company's Policy Number and Effective Date | | | |
| | | | |

Enrollment Application and Change Form

INSTRUCTIONS

Use this form, along with your Directory of Providers, and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1Complete all information.

SECTION 2Check the coverage plan you would like (Be sure to check with your employer to see which plans are being offered).
If you are choosing the Select Plus/POS Plan or the Select/EPO Plan, you must complete Section 6.

SECTION 3Select who should be covered on the plans.

SECTION 4Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5Fill in the appropriate action code for completing this form:
A = To add a dependent to your benefit plan
T = To terminate your or a dependent's coverage
C = To change information about yourself or a dependent
Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked Other Insurance and complete Section 7. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is disabled or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6If you have chosen the Select Plus/POS or Select/EPO Plan, choose a Primary Care Physician for each listed individual from the appropriate Directory. List the Primary Care Physician's name, office zip code and indicate if the member is currently a patient of that physician. List the physician's 13-digit ID number listed in the directory.

SECTION 7This section must be completed for all new enrollments or coverage changes.

SECTION 8The employee must sign and date this form in order for it to be processed.

SECTION 9This section is to be completed by the employer's benefit representative.