

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

Group Name/Number

To Be Completed by Employer	<input type="checkbox"/> New <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Cancel Eff/Change Date ___/___/___		
Group Specifics	Reason for Application <input type="checkbox"/> New Group Plan <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Life event/date _____ <input type="checkbox"/> Other _____	Product Selection Health <input type="checkbox"/> Yes <input type="checkbox"/> No Life <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Dep Life <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Vision <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____	Employee Type Active <input type="checkbox"/> Yes <input type="checkbox"/> No COBRA./St Cont <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date ___/___/___ End Date ___/___/___ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union Other _____
Position/Title _____ Hours Worked _____ Plan Selected Medical _____ Dental _____	A. Employee Information		
DATE OF HIRE _____			

First Name	MI	Last Name	Social Security Number	Home Phone
				Work Phone
Address		Apt #	City	State
				Zip
Email Address				

B. Family Information	List All Enrolling (Attach sheet if necessary)						Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Last Name	First Name	MI	Sex	Relationship**	Birthdate	Height	Weight	Physician*(First and Last Name)
Employee			M F	Self				
			M F					
			M F					

*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. If dependent does not reside with eligible employee, please provide address on a separate sheet.

C. Product Selection									Dual Option Plan Number
(Please check all that apply)*									
Person	Medical	Life	Sup Life	Sup AD&D	Dental	Vision	STD	LTD	
Employee		\$	\$	\$					
Spouse		\$							
Dependents		\$							

*Benefit offerings are dependent upon employer election	Life Beneficiary's Full Name and Address
	Relationship

D. Other Coverage Information			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has anyone on this application been covered with health benefits, including coverage with UnitedHealthcare within the past 2 years?	List dates covered	List all family members covered
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you or any of your dependents covered by Medicare?	Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease	Covered by Part <input type="checkbox"/> A <input type="checkbox"/> B
If yes, Name of Medicare Beneficiary		Date Medicare became effective	Claim Number

E. Waiver of Coverage	Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> Other _____ <input type="checkbox"/> I (we) have no other coverage at this time	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.		
I decline coverage for: <input type="checkbox"/> Myself and all dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children		<table border="1" style="width: 100%;"> <tr> <td style="width: 70%;">Employee Initials</td> <td>Date</td> </tr> </table>	Employee Initials	Date
Employee Initials	Date			

F. Signature	I authorize United HealthCare Insurance Company and its affiliates ("The Company 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 The Company and Affiliates. I understand the purpose of the disclosure and use of my information is to allow The Company 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 The Company and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the 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.		
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F. Signature (continued)

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 The Company 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.

Date _____	Employee Signature for all applying and waiving _____	Spouse Signature (if applicable) _____
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G. Medical History

Employee Name _____ SSN _____ Group Name _____

Have you - or any person listed in section B "Family Information" on the front of this form - 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.**

1A Cancer/Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____
1B Heart/Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Skin Ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other _____
1C Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date____) <input type="checkbox"/> Multiples Expected (#____) <input type="checkbox"/> Pregnancy Complications (Current or Past) <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
1D Intestinal/Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Hiatal Hernia/Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other _____
1E Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other _____
1F Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Other _____
1G Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____
1H Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____
1I Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
1J Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Arthritis (Rheumatoid or Osteo) <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Pituitary Dwarfism <input type="checkbox"/> Pulled/Strained Muscle <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other Back/Neck Disorder <input type="checkbox"/> Other _____
2 Mental Health/ Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other _____
3 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Organ _____
4 Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications <input type="checkbox"/> Medications Taken Within The Past Year
5 Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition or Congenital Disorder Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised, But Not Yet Done <input type="checkbox"/> Unexplained Weight Change
6 Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anyone On This Application Used Tobacco Products In The Past 12 Months Name _____

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/Complications	Physician's Name	Dates Treated	Prognosis