Enrollment Application/Change/Cancellation Request

Ohio

UnitedHealthcare®

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by ☐ UnitedHealthcare Insurance Company, ☐ UnitedHealthcare Life Insurance Company or ☐ UnitedHealthcare of Ohio, Inc.
Dental coverage provided by ☐ UnitedHealthcare Insurance Company or ☐ UnitedHealthcare of Ohio, Inc.
Life Insurance coverage provided by ☐ UnitedHealthcare Insurance Company
Vision coverage provided by ☐ UnitedHealthcare Insurance 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			#Hours worked per week
☐ Union ☐ Non-union	☐ Salaried ☐ Hourly	☐ Active ☐ COBRA/State Cont. ☐ Retire Date _____	

Signature _____ Date _____

Employer Position_____ Phone Number_____

A. Employee Information

Last Name	First Name	MI	Social Security Number
			___ – ___ – ___

Address	Apt #	City	State	Zip Code	Home/Cell Phone

Date of Birth	Sex	Marital Status	Work Phone
/ /	☐ M ☐ F	☐ Single ☐ Divorced ☐ Married ☐ Widowed	

Email Address	Race – Check all that apply (Optional)[2]
	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
Language Preference, if not English	☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
	☐ Other–Please specify _____

Primary Physician[1]	Primary Dentist[1]
Physician First & Last Name _____	Dentist First & Last Name _____
ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___	ID# _____

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

[2]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.

B. Family Information

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

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Spouse /Domestic Partner				☐ M ☐ F	____ /____ /______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ____ ID# ____ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____			Primary Care Dentist[1] Name: ____ ID# ____		
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	____ /____ /______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ____ ID# ____ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____			Primary Care Dentist[1] Name: ____ ID# ____		
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	____ /____ /______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ____ ID# ____ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____			Primary Care Dentist[1] Name: ____ ID# ____		
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	____ /____ /______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ____ ID# ____ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____			Primary Care Dentist[1] Name: ____ ID# ____		

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.
[2]For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.
[3]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 the box for each coverage in which you or your dependents are enrolling.
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	Voluntary AD&D
Employee	☐ ______	☐ ______	☐	☐ $______	☐ $______	☐ $______
Spouse [Domestic Partner]	☐	☐	☐	☐ $______	☐ $______	☐ $______
Dependent	☐	☐	☐	☐ $______	☐ $______	☐ $______

Person	STD	LTD	STD Buy Up	LTD Buy Up	Salary $ ______ Required only if Life, STD, or LTD based on salary
Employee	☐	☐	☐	☐	

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

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

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

(continued on next page)

F. Signature (Continued)

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

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. 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 at the end of this form.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

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 at the 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.