UnitedHealthcare®
A UnitedHealth Group Company

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

Group Name/Number

To Be Completed by Employer

☐ New ☐ Dependent Add/Delete ☐ Change Name/Address ☐ Cancel ☐ Date of Change

Group Specifics

Position/Title

Hours Worked

Plan Selected
Medical
Dental

Reason for Application
☐ New Group Plan
☐ Annual Open Enrollment
☐ New Hire
☐ Status Change
☐ Life event/date
☐ Other
☐ Date of Hire

Product Selection
Health ☐ Yes ☐ No
Life ☐ Yes ☐ No
$
Dep Life ☐ Yes ☐ No
Dental ☐ Yes ☐ No
Vision ☐ Yes ☐ No
Other

Employee Type
Active ☐ Yes ☐ No
COBRA./St Cont ☐ Yes ☐ No
Hourly ☐ Yes ☐ No
Salary ☐ Yes ☐ No
Union ☐ Yes ☐ No
Non-Union ☐ Yes ☐ No
Other

A. Employee Information

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** ☐ Single ☐ Married

Last Name First Name MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time	Physician*(First and Last Name)
Employee	M F	Self				Student	
	M F	Spouse/Dom. Partner					
	M F					☐ 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 a separate sheet.

C. Product Selection

(Please check all that apply)*

Person	Medical	Life	Sup Life	Sup AD&D	Dental	Vision	[STD]	[LTD]	Dual Option Plan Number
Employee		$	$	$					
Spouse		$							
Dependents		$							

*Benefit offerings are dependent upon employer election

Life Beneficiary's Full Name and Address

Relationship

D. Other Coverage Information

☐ Yes ☐ 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

☐ Yes ☐ No Are you or any of your dependents covered by Medicare?

Reason ☐ Over 65 ☐ Disabled ☐ Kidney Disease

Covered by Part ☐ A ☐ B

If yes, Name of Medicare Beneficiary

Date Medicare became effective

Claim Number

E. Waiver of Coverage

I decline coverage for:
☐ Myself and all dependents
☐ Spouse
☐ Dependent Children

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 ☐ Other
☐ 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.

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 from the past 5 years, 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.

(continued on back)

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)

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