

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

Enroll  
 Cancel  
 Change

Address Change  
 Name 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  Home  Work

Marital Status  Single  Divorced  Married  Widowed Sex  M  F Birthdate \_\_\_\_\_ Height/Weight \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ lbs.

**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**	Height/Weight	Full-Time Student
<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:
	SS#			-		-		
<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:
	SS#			-		-		
<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:
	SS#			-		-		

\*IMPORTANT: \*\*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)**

<p><b>MEDICAL BENEFITS:</b></p> <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)	<p><b>DENTAL BENEFITS:</b></p> <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 child(ren) Reason: <input type="checkbox"/> Covered under another plan <input type="checkbox"/> Other: _____ <small>Dental benefits provided by United HealthCare Insurance Company</small>	<p><b>LIFE INSURANCE PRODUCTS*</b></p> Salary \$ _____ <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr <input type="checkbox"/> Life/Accidental Death or Dismemberment <input type="checkbox"/> Dependent Life Insurance  Life Beneficiary's Full Name and Address _____ Relationship _____  <small>Insurance products provided by United HealthCare Insurance Company</small>	<p><b>Benefit Level/Class Code</b></p> <table border="1"> <tr> <th>Benefit Level/Class Code</th> </tr> <tr> <td> </td> </tr> <tr> <td> </td> </tr> <tr> <td> </td> </tr> </table>	Benefit Level/Class Code			
Benefit Level/Class Code							

**D. To Be Completed By Employer**

Company Name \_\_\_\_\_ Group # \_\_\_\_\_ Plan Variation \_\_\_\_\_ Medical \_\_\_\_\_ Dental \_\_\_\_\_ Department Number \_\_\_\_\_ Date of Employment \_\_\_\_\_

**New Enrollment/Additions: (Check one)**  
 Date of Hire \_\_\_/\_\_\_/\_\_\_ Requested Date of Coverage \_\_\_/\_\_\_/\_\_\_ (attach COBRA Election Form)  
 New Hire  Status Change (PT to FT)  
 Return from Leave/Layoff  
 Birth  Marriage  Adoption (attach legal documentation)  
 Court ordered dependent (attach documentation)  
 Other (describe) \_\_\_\_\_  
 COBRA/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 listed above – Section B  
 Reason: (check one)  
 Death  Employee Terminated  Divorce  
 Moved out of service area  
 Dependent reached student/dependent max age  
 Other (describe) \_\_\_\_\_

**Product Selections – Check all that apply**  Union  Non-union  Active  Retired/Date \_\_\_\_\_

UnitedHealthcare Choice Plus  
 UnitedHealthcare Managed Indemnity  
 UnitedHealthcare Options PPO  
 Kentucky Standard Plan POS

**DENTAL PLANS**  
 UnitedHealthcare Dental Options PPO

**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/Employer Position \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

**E. Other Medical Coverage Information / Waiver**

**(This section must be completed)**

Social Security #                -                -               

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 medical coverage (Including Medicare) \_\_\_\_\_

Medicare effective date \_\_\_\_\_ Reason for Medicare eligibility:  Over 65  Disabled  Kidney Disease Medicare Claim # \_\_\_\_\_  
Parts A&B

**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.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_  
(only sign if you are waiving coverage)

**Medical History (applicable for groups of one to 9)**

Have you or your dependents been diagnosed, treated, received counseling or advice during the past 5 years for any of the following: PLEASE CHECK AND EXPLAIN ALL THAT APPLY.

**Cancer/Tumor**  Lung  Breast  Liver  Colon  Leukemia/Lymphoma  Melanoma  
 Yes  No **1**  Other \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_ Stage/Level \_\_\_\_\_

**Heart/Circulatory**  High Blood Pressure  Stroke  Aneurism  Heart Disease  Hemophilia  Blood Disorder  Skin Ulcer  
 Yes  No **2**  Varicose Veins  Phlebitis  Congestive Heart Failure  Bypass/Angioplasty  
 Elevated Cholesterol/Triglycerides  Other \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Reproductive** Current Pregnancy (due date \_\_\_\_\_)  Multiples expected \_\_\_\_\_  Pregnancy Complications (current or past)  
 Yes  No **3**  Infertility  Endometriosis  Breast Disorders  Other \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Intestinal/Endocrine**  Gallbladder  Liver Disorder  Hepatitis B/C  Colon Disorder (provide diagnosis)  Crohn's/Ulcerative Colitis  
 Yes  No **4**  Diabetes  Ulcer  Chronic Pancreatitis  Hiatal Hernia/Reflux  Other \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Brain/Nervous**  Multiple Sclerosis  Paralysis  Cerebral Palsy  Migraines  Parkinson's Disease  Alzheimer's Disease  
 Yes  No **5**  Other \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Immune**  Lupus  Other \_\_\_\_\_  
 Yes  No **6** Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_  
Have you or your dependents tested positive for HIV/AIDS?  Yes  No

**Lung/Respiratory**  Asthma  Allergies  Cystic Fibrosis  Emphysema/Chronic Bronchitis  
 Yes  No **7**  Pneumonia  Tuberculosis  Sleep Apnea  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Eyes/Ears/  
Nose/Throat**  Retinopathy  Cleft lip/palate  Chronic Sinusitis  Deviated Septum  Acoustic Neuroma  Glaucoma  
 Yes  No **8**  Cataracts  Chronic Ear Infections  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Urinary/Kidney**  Renal Failure  Polycystic Kidney Disease  Neurogenic Bladder  
 Yes  No **9**  Kidney Stones  Prostate Disorder  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Bones/Muscles**  Bulging/Herniated Disc  Pituitary Dwarfism  Spina Bifida  Arthritis (Rheumatoid or Osteo)  Joint Injury  
 Yes  No **10**  Pulled/Strained muscle  Other back/neck disorders Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Mental Health/  
Substance  
Abuse**  Bipolar/Manic Depression  Eating Disorder  Anxiety/Depression  Alcoholism  Drug Abuse  
 Yes  No **11**  Suicide Attempt  Attention Deficit Disorder  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Transplant**  Organ \_\_\_\_\_  Bone Marrow  Surgery Completed (Date \_\_\_\_\_)  Discussed possible future transplant  
 Yes  No **12** Patient Name \_\_\_\_\_ Rejections/Complications \_\_\_\_\_  
 Current Treatment \_\_\_\_\_  
 (Date \_\_\_\_\_) Current Status \_\_\_\_\_

**Medication**  Current Medications Patient Name \_\_\_\_\_  
 Yes  No **13** Medication Name \_\_\_\_\_  
 Medications within the past year Patient Name \_\_\_\_\_  
 Medication Name \_\_\_\_\_ Date Last Taken \_\_\_\_\_

**Other**  Treatment or surgery discussed or advised, but not yet done  
 Yes  No **14**  Condition or Congenital Disorder not mentioned above  
 Abnormal test or physical results  Unexplained Weight Change  
 Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 Details \_\_\_\_\_

Yes  No **15** Has anyone on this application used tobacco products in the past 12 months? Name \_\_\_\_\_

**IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SHEET AND BE SURE TO DATE AND SIGN THAT SHEET.**

**Signature** (Form must be signed)

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

I confirm that the information I have provided on this form are representations and not warranties.

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 pursuant to Federal and State laws.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Note: Only the applicant may change or alter information contained in this form. Any changes made by other parties, will be allowed only with the written consent of the applicant.

Date \_\_\_\_\_ Employee Signature \_\_\_\_\_ Spouse Signature \_\_\_\_\_  
 (if possible) and applicable

**KENTUCKY AND INDIANA INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN KENTUCKY AND INDIANA TO SMALL EMPLOYERS OF 2-50 EMPLOYEES. 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.**

**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 [www.uhc.com](http://www.uhc.com), 1-800-495-5285 or your employer.

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 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.
4. 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.
5. 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.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
7. 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 named 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 24 months from the date of this form. 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.

Social Security #    -    -

UnitedHealthcare of Kentucky  
2424 Harrodsburg Road, Suite 300, Lexington, KY 40503

Insurance products provided by United HealthCare Insurance Company  
Dental Benefits provided by United HealthCare Insurance Company