

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

Enroll Address Change
 Cancel Name Change
 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 _____ [Physician*] _____ [Physician's ID No.] _____ [Are you a current patient?] Yes No

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**	Full-Time Student	[Physician*]	[Are you a Current Patient?]
	Dependent Social Security No.							[Physician's ID Number]	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -	M F					<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -	M F					<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -	M F					<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____		<input type="checkbox"/> YES <input type="checkbox"/> 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 separate sheet.

C. Product Selection (check all that apply)

<p>MEDICAL BENEFITS:</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) <small>[Non-network][and][medical] insurance benefits provided by [United HealthCare Insurance Company]</small>	<p>DENTAL BENEFITS:</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>LIFE INSURANCE PRODUCTS*</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 <input type="checkbox"/> [Supplemental Life] <input type="checkbox"/> [Suppl. Accidental Death and Dismemberment] <input type="checkbox"/> [Critical Illness] Life Beneficiary's Full Name and Address _____ Relationship _____ <small>[Insurance products provided by [United HealthCare Insurance Company]]</small>	<p>Benefit Level/Class Code</p> <table border="1"> <tr><th>Benefit Level/Class Code</th></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>	Benefit Level/Class Code					
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[OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)]
 UnitedHealthcare Overture Classic UnitedHealthcare Overture Performance UnitedHealthcare Overture Premier

D. To Be Completed By Employer

Company Name _____ Group # _____ Plan Variation _____ Medical _____ Reporting Code _____ Medical _____ Dental _____ Department # _____

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 [Salaried] [Hourly] Active Retired/Date _____

[UnitedHealthcare Choice] [UnitedHealthcare Choice Plus] **DENTAL PLANS**
 [UnitedHealthcare Select HMO] [UnitedHealthcare Select EPO] [UnitedHealthcare Dental Managed Indemnity]
 [UnitedHealthcare Managed Indemnity] [UnitedHealthcare Options PPO] [UnitedHealthcare Dental Options PPO]
 [UnitedHealthcare Select Plus POS] [UnitedHealthcare Select Plus HMO]
 [Kentucky Standard Plan HMO] [Kentucky Standard Plan POS]
 [UnitedHealthcare Rhapsody] [UnitedHealthcare Overture Package: _____ (A-S)]

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 # _____

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.\[xxx\].com](http://www.[xxx].com), 1-800-[xxx-xxxx] or [name of employer/broker contact].

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.

[UnitedHealthcare of Kentucky]
[2424 Harrodsburg Road, Lexington, KY 40504-3329]

Insurance products provided by United HealthCare
Insurance Company

Dental benefits provided by United HealthCare
Insurance Company