

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. SS# -			M F				<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____
<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"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -			M F				<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____

*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>MEDICAL BENEFITS:</p> <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) medical insurance benefits provided by United HealthCare Insurance Company</p>	<p>DENTAL BENEFITS:</p> <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: _____ Dental benefits provided by United HealthCare Insurance Company</p>	<p>LIFE INSURANCE PRODUCTS*</p> <p>Salary \$ _____ <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr</p> <p><input type="checkbox"/> Life/Accidental Death or Dismemberment <input type="checkbox"/> Dependent Life Insurance</p> <p>Life Beneficiary's Full Name and Address _____ Relationship _____</p> <p>Insurance products provided by United HealthCare Insurance Company</p>	<p>Benefit Level/Class Code</p> <p>Benefit Level/Class Code _____</p>
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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 Managed Indemnity
 UnitedHealthcare Options PPO
 UnitedHealthcare Choice Plus

DENTAL PLANS
 UnitedHealthcare Dental Managed Indemnity
 UnitedHealthcare Dental Options PPO

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review sections A-D 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
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Coverage type: Group Policy Individual Policy Medicare/Medicaid Other _____

Is this coverage through your spouse's employer? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
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Employee's relationship to policyholder	Names of family members with other medical coverage (Including Medicare)
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Medicare effective date Parts A&B	Reason for Medicare eligibility: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease	Medicare Claim #
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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 _____)

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/ Retinopathy Cleft lip/palate Chronic Sinusitis Deviated Septum Acoustic Neuroma Glaucoma
Nose/Throat Cataracts Chronic Ear Infections Other _____
 Yes No **8** 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/ Bipolar/Manic Depression Eating Disorder Anxiety/Depression Alcoholism Drug Abuse
Substance Suicide Attempt Attention Deficit Disorder Other _____
Abuse Yes No **11** 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 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 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.

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

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, 1-800-382-5445 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 may use individually identifiable information about you to identify for you (and you alone) procedures, products or 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 physician'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 physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician 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 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.

Date _____ Employee Signature _____ Spouse Signature _____
(if possible) and applicable

Insurance products provided by United HealthCare Insurance Company

Dental Benefits provided by United HealthCare Insurance Company