

# Employee Enrollment Form

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

**To Be Completed by Employer** Requested Effective Date of Coverage/Date of Change / /

Group Name/Policy Number

<b>Date of Hire</b> / /	<b>Reason for Application</b> <input type="checkbox"/> New Group Plan <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Waiving Coverage <input type="checkbox"/> Termination <input type="checkbox"/> Other _____	<input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Late Enrollee	<b>Employee Type</b> (Check all that apply) <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation Start dt ____/____/____ End dt ____/____/____
Position/Title			<input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired <input type="checkbox"/> Other _____
Hours Worked per week			
Salary \$ _____ Required only if Life, STD, or LTD Plan based on salary			

**A. Employee Information** If you are waiving all coverage, please complete sections A and G.

Last Name		First Name		MI	Social Security Number		Home/Cell Phone Work Phone	
Address			Apt #	City		State	Zip Code	Language preference, if not English
Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Physician* (First & Last Name)/ ID #			Primary Care Dentist** (First & Last Name)/ ID #			

**B. Family Information** List All Enrolling (Attach sheet if necessary)

Last Name	First Name	MI	Sex	Relationship***	Birthdate	Height	Weight	Physician* (Name/ID#)	Primary Care Dentist** (Name/ID#)	Tobacco Used
			M F	Spouse [//Domestic Partner]						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No
			M F	Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Important: For UnitedHealthcare Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician, you must use the UnitedHealthcare directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents.  
 \*\*Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. \*\*\*For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Coverage Provided by "UnitedHealthcare and Affiliates":  
 Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Louisiana, Inc.  
 Dental coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Louisiana, Inc.  
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company  
 Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Employee Name \_\_\_\_\_

**C. Product Selection** **Please check the box for each coverage you or your dependents are enrolling in.**  
 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
Employee	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Spouse [Domestic Partner]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____

Person	STD	STD Buy Up	LTD	LTD Buy Up	
Employee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	

Life Insurance Beneficiary's Full Name and Address	Relationship
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**D. Prior Medical Insurance Information** **This section must be completed to receive credit for prior medical coverage.**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?  
 NO  YES (if yes, please complete this section.)  
 Prior medical carrier name \_\_\_\_\_ Effective date \_\_\_/\_\_\_/\_\_\_ End date \_\_\_/\_\_\_/\_\_\_  
 Prior coverage type:  Employee  Spouse  Child(ren)  Family

**E. 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 MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
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  
 Are you receiving Social Security Disability Insurance (SSDI)?  YES  NO Start Date \_\_\_/\_\_\_/\_\_\_

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.  
 \*\* If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.



