

Employee Enrollment Form



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

Group Name/Number

To Be Completed by Employer		Requested Effective Date of Coverage/Date of Change / /	
Date of Hire / /	Reason for Application	Employee Type (Check all that apply)	
Position/Title	<input type="checkbox"/> New Group Plan	<input type="checkbox"/> New Hire	
Hours Worked per week	<input type="checkbox"/> Life Event/Date _____	<input type="checkbox"/> Annual	
Salary \$ _____ Required only if Life Plan based on salary	<input type="checkbox"/> Status Change _____	<input type="checkbox"/> Open Enrollment	
	<input type="checkbox"/> Dependent Add/Delete	<input type="checkbox"/> Late Enrollee	
	<input type="checkbox"/> Change Name/Address	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired	

A. Employee Information

Last Name		First Name		MI	Social Security Number		Home Phone	Work Phone
Address		Apt #	City		State	Zip Code	Email Address	
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		Language preference, if not English		
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)			Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (Name/ID#)	Tobacco Used
Last Name	First Name	MI							Primary Care Dentist (Name/ID#)	
_____	_____	_____	M F	Spouse	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	M F	Dependent	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	M F	Dependent	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	M F	Dependent	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<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 products requiring a Primary Physician designation 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. Benefit offerings are dependent upon employer selection. Dual Option Plan Selected

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Medical	Dental
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Dependents	<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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Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Georgia, Inc.
Dental coverage provided by United HealthCare Insurance Company or United HealthCare of Georgia, Inc.
Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

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 workAre 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.

F. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form. Please answer completely and truthfully.

 Yes No 1. Is anyone on this application currently pregnant? If "yes" please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section. Yes No 2. Has anyone on this application visited any health care professional during the last 10 years for any illness, injury, or health condition? If your answer is "yes" please provide detailed information on next page for each person involved. Yes No 3. Has anyone on this application been hospitalized (inpatient or outpatient) or had surgery in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved. Yes No 4. Has anyone on this application been prescribed or taken any prescription medications in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved. Yes No 5. Does anyone on this application have a health condition, illness, or injury that may require treatment or surgery, or has any health care professional recommended treatment or surgery for any of you that has not been performed? If your answer to either question is "yes" please provide detailed information below for each person involved.**Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)**

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

