

Employee Name _____

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

Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Spouse /Domestic Partner	Social Security Number	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist³ Dentist First & Last Name _____ ID# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship ⁴	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number	Do you use tobacco? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Primary Care Physician² Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID# _____	Primary Care Dentist³ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older ⁵ <input type="checkbox"/> Yes <input type="checkbox"/> No
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(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

C. Product Selection **Please check the box for each coverage in which you or your dependents are enrolling.**

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	LTD			
Employee	<input type="checkbox"/>	<input type="checkbox"/>			

Employee Name _____

C. Product Selection (continued)

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

D. Prior Medical Insurance Information

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.

F. Waiver of Coverage I decline all coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents	Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Other _____	I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.
	Date _____ Employee Signature if waiving coverage _____	

G. Signature

I authorize "The Company(ies)" checked on page one to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to "The Company(ies)". I understand that the purpose of the disclosure and use of my information is to allow "The Company(ies)" to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my "Company(ies)" representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, "The Company(ies)" also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, is valid for 30 months from the date it is signed (and for the term of coverage of the policy for the purpose of collecting information in connection with reviewing and/or processing a claim for benefits). I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that I am completing a joint life and health application and that each response must be complete and accurate to the best of my knowledge and belief. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that "The 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 application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective. In accordance with Virginia law, the validity of a policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. In addition, and in accordance with Virginia law, no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1.) After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2.) Unless the statement is contained in a written instrument signed by him. This shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

Please maintain a copy of this authorization for your records.

You or your authorized representative are entitled to receive a copy of this authorization.

I certify that I have read, or have had read to me, this completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
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H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: White Black, African-American American Indian/Alaska Native Asian
 Native Hawaiian/Pacific Islander Other Race, please specify _____
2. Are you of Hispanic or Latino origin? Yes No