

Enrollment Application and Change Form



- NEW COVERAGE
 REQUEST FOR CHANGE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY.

1 EMPLOYEE INFORMATION							
LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	
HOME ADDRESS		CITY		STATE	ZIP CODE	HOME PHONE NUMBER ()	
EMPLOYER NAME UNIVERSITY OF HARTFORD				EMAIL ADDRESS		WORK PHONE NUMBER ()	

2 TYPE OF COVERAGE
<input type="checkbox"/> CORE Point of Service <input type="checkbox"/> ENHANCED Point of Service <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents <i>Reason:</i> <input type="checkbox"/> Covered under another plan. <input type="checkbox"/> Other: _____ (See Sec 7 & 8) <small>*Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered late enrollees if you enroll in this plan at a later date.</small>

3 WHO SHOULD BE COVERED
<input type="checkbox"/> Individual Only (01) <input type="checkbox"/> Individual + One Dependent (08) <input type="checkbox"/> Individual + Two or More Dependents (04)

4 TYPE OF CHANGE
<input type="checkbox"/> Add Dependent (complete Sec 5) <input type="checkbox"/> Reinstatement - Reason _____ <input type="checkbox"/> Terminate Dependent (complete Sec 5) <input type="checkbox"/> Surviving Spouse Former Employee SSN _____ <input type="checkbox"/> Address (enter above) <input type="checkbox"/> COBRA Continuee Former Employee SSN _____ <input type="checkbox"/> Primary Care Physician (complete Sec 6) <input type="checkbox"/> Other _____ <input type="checkbox"/> Name Change (complete Sec 5) <input type="checkbox"/> Terminate All Coverage - Reason _____

5 COVERAGE INFORMATION								
(Y) Add (T) Term (C) Chg	Last Name	First Name	MI	Zip Code	Date of Birth (Mo./Day/Yr.)	Sex	Handi- capped?	Full-Time Student Over 19?
	Employee		COB <input type="checkbox"/>					
	Spouse/Same Sex partner		COB <input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F		
	Child-1		COB <input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> Y <input type="checkbox"/> F <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child-2		COB <input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> Y <input type="checkbox"/> F <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child-3		COB <input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> Y <input type="checkbox"/> F <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 PRIMARY CARE PHYSICIAN INFORMATION		
REQUIRED FOR POINT OF SERVICE AND EXCLUSIVE PROVIDER/NETWORK PROVIDER PLANS		
Primary Care Physician (from Directory)	Existing Patient?	13-Digit PCP ID Number (from Directory)
	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Y <input type="checkbox"/> N	

7 OTHER INSURANCE
On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, Medicare or Medicaid? <input type="checkbox"/> Y <input type="checkbox"/> N Is another person legally responsible for coverage for your children? <input type="checkbox"/> Y <input type="checkbox"/> N If you answered yes to either of the questions above, please complete the following:
Person's Name with Other Health Plan _____ Social Security Number _____ Date of Birth _____ Sex _____ Other Company's Name and Phone Number _____ Other Company's Policy Number and Effective Date _____ Medicare Number _____ Part A Effective Date _____ Part B Effective Date _____

8 AUTHORIZATION
On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give The United HealthCare Insurance Company and its affiliates (and the employer) or any of their designees ("United HealthCare"), any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and / or my dependent's coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct. If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. <p style="text-align: center;">NOTICE OF ENROLLMENT RIGHTS</p> 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. I further understand that if I decline enrollment for myself or dependents (including my spouse/same sex partner) 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. Health insurance or medical services benefits provided or administered by The United HealthCare Insurance Company, Hartford, CT.
X Signature _____ Date _____

9 TO BE COMPLETED BY EMPLOYER								
DATE OF HIRE	DATE SUBMITTED	HEALTH/CHANGE EFF. DATE	POLICY NUMBER 165058	PLAN VARIATION/SUB	REPORTING CODE/BRANCH	EMPLOYER SIGNATURE	TITLE	DATE

Enrollment Application and Change Form

Instructions

Check the appropriate box to indicate if you are enrolling for the first time or making a change to your existing coverage. Use this form, along with your Directory of Providers, and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

SECTION 1 Complete all information.

SECTION 2 Check the type of coverage/plan you would like to enroll in.

SECTION 3 Identify who should be covered on the plan.

SECTION 4 Complete this section only if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5 Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan.

T = To terminate yourself or a dependent's coverage from your benefit plan.

C = To change information about yourself or a dependent on your benefit plan.

Print your full name and the full names of your covered dependents, if any. If any member enrolling in the plan has another health plan, check the box marked COB (Coordination of Benefits) and complete Section 7. Provide the zip code, date of birth and gender for each dependent. Check the appropriate boxes indicating if a dependent is handicapped or a full-time student. If you have more than four dependents, please attach an additional enrollment form.

SECTION 6 If Identify a Primary Care Physician for each listed covered dependent. List the Primary Care Physician's name and indicate if the covered dependent is currently a patient of that physician. List the Primary Care Physician's 13-digit ID number listed in the provider directory or on the United Healthcare website at www.myuhc.com or www.uhc.com.

SECTION 7 This section must be completed for all new enrollments or coverage changes.

SECTION 8 The employee must sign and date this form in order for it to be processed.

SECTION 9 This section is to be completed by the employer's benefit representative.