(DO NOT STAPLE)

CA Key Accounts Employee Enrollment Form

UnitedHealthcare®

UnitedHealthcare Insurance Company
UnitedHealthcare of California

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: _____		DBA (if applicable): _____		
	Product	**Group #**	**Plan Variation #**	**Reporting Code**
Date of Hire _____/_____/_____	Medical			
Position/Title	Dental			
Hours Worked per Week	Vision			

Reason for Application

☐ New Group Plan ☐ New Hire
☐ Life Event/Date__/__/__
☐ Status Change_____
☐ Dependent Add/Delete
☐ Change Name/Address
☐ Other_____
☐ Annual Open Enrollment
☐ Late Enrollee
☐ Rehire

Employee Type (Check all that apply)

☐ Active ☐ Union ☐ Non-Union ☐ Retired
☐ Hourly ☐ Salary ☐ Other _____
☐ Early Retiree
☐ COBRA ☐ Cal COBRA
Start date___/___/___ End date___/___/___
Indicate Qualifying Event _____
Original Qualifying Event Date
Begin date ___/___/___ End date___/___/___

Cancellations: Last Date of Employment __/__/__
Requested Effective Date of Cancellation __/__/__
☐ Cancel all coverage
☐ Cancel all listed below – Section B (family information)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached max age
☐ Other (describe)_____

A. Employee Information

Complete all sections. If you are waiving all coverage, please complete only Sections A and F.

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt. #	City	State	ZIP	E-mail address

Date of Birth	Sex	Marital Status	Have you or your dependents ever been a UnitedHealthcare member?	Preferred Language:
	☐ M ☐ F	☐Single ☐Married ☐Divorce ☐Widowed ☐Domestic Partner	☐Yes ☐No	☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____

Primary Care Physician(1) Name: _____
Address _____
ID# ___|___|___|___|___|___|___|___|___|___ Existing Patient ☐Yes ☐No

Primary Care Dentist(2) Name_____
ID#_____
Existing Patient ☐Yes ☐No

Have you used tobacco within the past 12 months? ☐Yes ☐No

B. Family Information

Complete all sections for all family members.

Check Appropriate Box	Name (Last, First, MI) Social Security Number	Sex	Relationship(4)	Birth Date	Used tobacco within the last 12 months?
☐ Enroll ☐ Cancel ☐ Change	___|___|___|-|___|___|-|___|___|___|___|	☐ M ☐ F	Spouse/ Domestic Partner	____/____/____	☐ Yes ☐ No

Address (if different from Employee)(3)

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other_____

Primary Care Physician(1) Name: _____
Address _____
ID# ___|___|___|___|___|___|___|___|___|___ Existing Patient ☐Yes ☐No

Primary Care Dentist(2) Name_____
ID#_____
Existing Patient ☐Yes ☐No

IMPORTANT: (1) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) Include address only if different from Employee. (4) For court-ordered dependent, legal documentation must be attached. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber/covered person 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.

Subscriber Last, First Name ______________________ SSN______________________

B. Family Information (cont.)

Complete all sections for all family members. (Attach sheet if necessary)

Check Appropriate Box	Name (Last, First, MI) / Social Security Number	Sex	Relationship[4]	Birth Date	Used tobacco within the last 12 months?
☐ Enroll ☐ Cancel ☐ Change	Name (Last, First, MI) Social Security Number ___|___|___-|___|___-|___|___|___|___|	☐ M ☐ F	Dependent	___/___/___	☐ Yes ☐ No
	Address (if different from Employee)	Permanently Disabled and age 26 or older[5] ☐ Yes ☐ No			
		Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other			
	Primary Care Physician[1] Name: ______ Address ______ ID# ___|___|___|___|___|___|___|___|___|___ Existing Patient ☐Yes ☐No	Primary Care Dentist[2] Name______ ID#______ Existing Patient ☐Yes ☐No			
☐ Enroll ☐ Cancel ☐ Change	Name (Last, First, MI) Social Security Number ___|___|___-|___|___-|___|___|___|___|	☐ M ☐ F	Dependent	___/___/___	☐ Yes ☐ No
	Address (if different from Employee)	Permanently Disabled and age 26 or older[5] ☐ Yes ☐ No			
		Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other			
	Primary Care Physician[1] Name: ______ Address ______ ID# ___|___|___|___|___|___|___|___|___|___ Existing Patient ☐Yes ☐No	Primary Care Dentist[2] Name______ ID#______ Existing Patient ☐Yes ☐No			
☐ Enroll ☐ Cancel ☐ Change	Name (Last, First, MI) Social Security Number ___|___|___-|___|___-|___|___|___|___|	☐ M ☐ F	Dependent	___/___/___	☐ Yes ☐ No
	Address (if different from Employee)	Permanently Disabled and age 26 or older[5] ☐ Yes ☐ No			
		Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other			
	Primary Care Physician[1] Name: ______ Address ______ ID# ___|___|___|___|___|___|___|___|___|___ Existing Patient ☐Yes ☐No	Primary Care Dentist[2] Name______ ID#______ Existing Patient ☐Yes ☐No			

IMPORTANT: (1) Please use the Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) Include address only if different from Employee. (4) For court-ordered dependent, legal documentation must be attached. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber/covered person 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

Check the box for each plan you or your dependents are enrolling in. Benefit offerings are dependent on employer selections.

Person	Medical	Dental	Vision	**Medical Plan and Dental Plan Selection –** Write in the Plan Code or Description of the Medical and Dental plan you wish to enroll in.
Employee	☐	☐	☐	
Spouse/ Domestic Partner	☐	☐	☐	**Medical Plan Code/Description:**______
Dependent	☐	☐	☐	**Dental Plan Code/Description:**______

Subscriber Last, First Name _____ SSN_____

D. Prior Medical Insurance/Health Plan Coverage Information

This section must be completed to receive credit for prior medical insurance/health plan coverage.

Within the last 12 months, have you, your spouse/domestic partner, or your dependents had any other medical coverage?
☐ NO ☐ YES (If YES, please complete this section and attach proof of coverage)

Prior medical carrier name_____ Effective date ___/___/___ End date ___/___/___

Policy # (if applicable) _____

Prior coverage type: ☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren) ☐ Family

Have you met any of your calendar year deductible? ☐ Yes ☐ No (If Yes, attach most current Explanation of Benefits/Explanation of Payment from the previous insurance company/health care service plan.)

E. Other Medical Insurance/Health Plan Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse/domestic partner 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 (If NO, then skip this section.)

Name of other carrier _____ Other carrier policy#_____

Other Medical Insurance/Health Plan 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/ covered employee for other insurance/ health plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent Name:		/ /	/ /	
Dependent Name:		/ /	/ /	
Dependent Name:		/ /	/ /	

† B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (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, please attach a copy of your Medicare ID card.)

Medicare ID# _____

☐ 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 ___ /___ /___

Subscriber Last, First Name _____ SSN_____

E. Other Medical Insurance/Health Plan Coverage Information (cont.)

Medicare – Spouse/Domestic Partner/Dependent Name: _____(If enrolled, please attach a copy of your Medicare ID card.)

Medicare ID# _____

☐ 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.

F. Waiver of Coverage

Complete only if you are waiving coverage for yourself and/or any family member.

I decline all coverage for:

	Medical	Dental	Vision
Myself	☐	☐	☐
Spouse/Domestic Partner	☐	☐	☐
Dependent Children	☐	☐	☐
Myself and all dependents	☐	☐	☐

Declining coverage due to existence of other coverage:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Tri-Care
☐ Covered by Medicare ☐ Medicaid ☐ I (we) have no other coverage at this time
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Cal-COBRA ☐ Cal-COBRA AB1401
☐ Other _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have been given the right and have been given the chance to apply for coverage. I have decided not to enroll myself and/or my dependent(s), if any.

I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in my employer health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THE GROUP MEDICAL AND THERE MAY BE A SIX-MONTH PRE-EXISTING CONDITION EXCLUSION UNLESS I AND/OR MY DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE. THE TWELVE (12)-MONTH WAIT WILL NOT APPLY IF I AND/OR MY DEPENDENTS ARE ENTITLED TO AN OFF-CYCLE ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.)** The twelve (12)-month wait will not apply if:

1. I certify at the time of initial enrollment that the coverage under another employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment and I lose coverage under that employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal;
2. my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period;
3. a court orders that I provide coverage under this plan for a spouse or minor child; or
4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 30 days after the marriage, domestic partnership, birth, adoption or placement for adoption.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Any references to Preexisting Conditions do not apply to anyone under the age of 19 whose plan is subject to health care reform contained in the Affordable Care Act.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be declined coverage entirely.

Employee Signature (only if waiving coverage for self and/or dependents) | Date _____/_____/_____

Subscriber Last, First Name _____ SSN_____

G. Authorization to Release Medical Information and Signature

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") 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, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request 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 (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a health application and that each response must be complete and accurate. 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) have not given the agent or any other persons any health information not included on the Request for 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 Coverage and any attachments. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Please maintain a copy of this authorization for your records.

Employee Signature	Employee Name (please print)	Date
		_____/_____/_____

H. Binding Arbitration

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Employee Signature (Required)	Employee Name (please print) (Required)	Date (Required)
		_____/_____/_____

I. Census Information

NOTE: 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.

Race, check all that apply:

- ☐ White
- ☐ Black, African-American
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Other Race, please specify_____

Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by United Healthcare Services, Inc., OptumRx, Inc or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH). Dental coverage provided by UnitedHealthcare Insurance Company and Dental Benefit Providers of California, Inc. Vision coverage provided by UnitedHealthcare Insurance Company.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.