

CA Key Accounts Employee Enrollment Form

(DO NOT STAPLE)



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 <input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Life Event/Date ____/____/____ Annual <input type="checkbox"/> Status Change _____ Open Enrollment <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Rehire <input type="checkbox"/> Other _____	Employee Type (Check all that apply) <input type="checkbox"/> Active <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____ <input type="checkbox"/> Early Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> 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 ____/____/____ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel all listed below – Section B (family information) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached max age <input type="checkbox"/> Other (describe) _____
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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 <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner		Have you or your dependents ever been a UnitedHealthcare member? <input type="checkbox"/> Yes <input type="checkbox"/> No			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____				
Primary Care Physician ⁽¹⁾ Name: _____					Primary Care Dentist ⁽²⁾ Name _____						
Address _____					ID# _____						
ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No					Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No						
Have you used tobacco within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No											

B. Family Information			Complete all sections for all family members.						
Check Appropriate Box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Name (Last, First, MI)				Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship ⁽⁴⁾ Spouse/ Domestic Partner	Birth Date ____/____/____	Used tobacco within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Social Security Number								
	Address (if different from Employee) ⁽³⁾						Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____		
	Primary Care Physician ⁽¹⁾ Name: _____						Primary Care Dentist ⁽²⁾ Name _____		
Address _____						ID# _____			
ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No						Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> 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.

B. Family Information (cont.)		Complete all sections for all family members. (Attach sheet if necessary)				
Check Appropriate Box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Name (Last, First, MI)	Sex	Relationship ⁽⁴⁾	Birth Date	Used tobacco within the last 12 months?	
	Social Security Number	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address (if different from Employee)		Permanently Disabled and age 26 or older ⁽⁵⁾ <input type="checkbox"/> Yes <input type="checkbox"/> No			
			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other			
	Primary Care Physician ⁽¹⁾ Name: _____ Address _____ ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist ⁽²⁾ Name _____ ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
Check Appropriate Box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Name (Last, First, MI)	Sex	Relationship ⁽⁴⁾	Birth Date	Used tobacco within the last 12 months?	
	Social Security Number	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address (if different from Employee)		Permanently Disabled and age 26 or older ⁽⁵⁾ <input type="checkbox"/> Yes <input type="checkbox"/> No			
			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other			
	Primary Care Physician ⁽¹⁾ Name: _____ Address _____ ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist ⁽²⁾ Name _____ ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
Check Appropriate Box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Name (Last, First, MI)	Sex	Relationship ⁽⁴⁾	Birth Date	Used tobacco within the last 12 months?	
	Social Security Number	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address (if different from Employee)		Permanently Disabled and age 26 or older ⁽⁵⁾ <input type="checkbox"/> Yes <input type="checkbox"/> No			
			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other			
	Primary Care Physician ⁽¹⁾ Name: _____ Address _____ ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist ⁽²⁾ Name _____ ID# _____ Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No			

Detach here

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Plan Code/Description: _____ Dental Plan Code/Description: _____
Spouse/ Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 ___/___/___

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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# _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Enrolled in Part A: Effective Date ____ / ____ / ____ | <input type="checkbox"/> Ineligible for Part A* | <input type="checkbox"/> Not Enrolled in Part A (chose not to enroll) |
| <input type="checkbox"/> Enrolled in Part B: Effective Date ____ / ____ / ____ | <input type="checkbox"/> Ineligible for Part B* | <input type="checkbox"/> Not Enrolled in Part B (chose not to enroll) |
| <input type="checkbox"/> Enrolled in Part D: Effective Date ____ / ____ / ____ | <input type="checkbox"/> Ineligible for Part D* | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myself and all dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Declining coverage due to existence of other coverage:

- | | | |
|--|---|---|
| <input type="checkbox"/> Spouse's Employer's Plan | <input type="checkbox"/> Individual Plan | <input type="checkbox"/> Tri-Care |
| <input type="checkbox"/> Covered by Medicare | <input type="checkbox"/> Medicaid | <input type="checkbox"/> I (we) have no other coverage at this time |
| <input type="checkbox"/> COBRA from Prior Employer | <input type="checkbox"/> VA Eligibility | |
| <input type="checkbox"/> Cal-COBRA | <input type="checkbox"/> Cal-COBRA AB1401 | |
| <input type="checkbox"/> 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

____ / ____ / ____

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 ____ / ____ / ____
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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) ____ / ____ / ____
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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:

<input type="checkbox"/> White	<input type="checkbox"/> Black, African-American	<input type="checkbox"/> American Indian/Alaska Native
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> Other Race, please specify _____
<input type="checkbox"/> Hispanic/Latino		

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.

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