☐ NEW COVERAGE
☐ REQUEST FOR CHANGE

Enrollment Application and Change Form

PLEASE PRINT CLEARLY.

UNITEDhealthcare℠

1 EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS
			☐ Male ☐ Female			☐ Single ☐ Married

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER
				( )

EMPLOYER NAME	DIVISION/LOCATION:				WORK PHONE NUMBER
CITY OF TAKOMA PARK	PARTTIME/ FULLTIME:	☐ UNION ☐ NONUNION	☐ HOURLY ☐ SALARY	☐ ACTIVE ☐ RETIRED Date _____	( )

2 TYPE OF COVERAGE

Choose One Medical & Dental Plan Only

Medical:
- ☐ Choice Plus
- ☐ Choice
- ☐ Choice HSA
- ☐ I decline coverage for myself
- ☐ I decline coverage for my dependents

Dental:
- ☐ High Option
- ☐ Low Option

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.

3 WHO SHOULD BE COVERED

Check One for Each Coverage

Medical:	**Dental:**
☐ Employee Only	☐ Employee Only
☐ Employee + Spouse	☐ Employee + Spouse
☐ Employee + Child(ren)	☐ Employee + Child(ren)
☐ Family	☐ Family

4 TYPE OF CHANGE - If Applicable

- ☐ Add Spouse/Child (complete Sec 5)
- ☐ Terminate Spouse/Child (complete Sec 5)
- ☐ Address (enter above)
- ☐ Primary Care Physician (complete Sec 6)
- ☐ Name Change (complete Sec 5)
- ☐ Terminate All Coverage – Reason _____
- ☐ Reinstatement – Reason _____
- ☐ Surviving Spouse Former Employee SSN _____
- ☐ COBRA Continuee Former Employee SSN _____
- ☐ Other _____

5 COVERAGE INFORMATION

	Last Name	First Name	MI	SSN	Zip Code	Date of Birth (Mo./Day/Yr.)	Sex	Handi-capped?
Employee								
Spouse							☐ M ☐ F	
Child-1							☐ M ☐ F	☐ Y ☐ N
Child-2							☐ M ☐ F	☐ Y ☐ N
Child-3							☐ M ☐ F	☐ Y ☐ N

6 PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician (from Directory)	Existing Patient?	13-Digit PCP ID Number (from Directory)
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ 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? ☐ Y ☐ N

Is another person legally responsible for coverage for your children? ☐ Y ☐ 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. I can cancel this direction in writing at any time.

NOTICE OF ENROLLMENT RIGHTS

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) 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	GRP/SUBGRP/BNFT GRP	PLAN VARIATION/SUB	REPORTING CODE/BRANCH	EMPLOYER SIGNATURE