

Enrollment Application and Change Form

PLEASE READ INSTRUCTIONS ON REVERSE SIDE.



New Coverage Request for Change

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		Division/Location UNIVERSITY OF HARTFORD				Work Phone Number ()

2 TYPE OF MEDICAL COVERAGE	3 WHO SHOULD BE COVERED	4 TYPE OF CHANGE
<input type="checkbox"/> POS Plan <input type="checkbox"/> Deductible -Based Plan <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents Reason: <input type="checkbox"/> covered under another plan <input type="checkbox"/> Other: _____ (see sections 6&7)	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child(ren) <input type="checkbox"/> Employee plus spouse plus child(ren)	<input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec. 5) <input type="checkbox"/> Terminate All Coverage - Reason _____ <input type="checkbox"/> Reinstatement - Reason _____ <input type="checkbox"/> Surviving Spouse - Former Employee SSN _____ <input type="checkbox"/> COBRA Continuee - Former Employee SSN _____ <input type="checkbox"/> Other _____

**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 a late enrollee if you enroll in this plan at a later date.*

5 COVERAGE INFORMATION									
(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Social Security Number	Date of Birth (MM/DD/YY)	Sex	Other Insurance	Disabled	
	Employee								
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
	Child 1					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	Child 2					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	Child 3					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

6 OTHER INSURANCE			
On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another UnitedHealthcare plan, 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	

7 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 UnitedHealthcare and its affiliates (and the employer) or any of their designees, 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 dependents' 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 employees 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; font-size: small;">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 my 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 UnitedHealthcare Insurance Company, Minneapolis, MN. X Signature _____ Date _____

8 TO BE COMPLETED BY EMPLOYER							
Date of Hire	Date Submitted	Health/Change Eff. Date	Policy Number 165058	GRP/SUBGRP/BNFT GRP	Plan Variation/Sub	Reporting Code/Branch	Employer Signature

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INSTRUCTIONS

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1Complete all information.

SECTION 2Check the coverage plan you would like.

SECTION 3Select who should be covered on the plans.

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

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

A = To add a dependent to your benefit plan

T = To terminate your or a dependent's coverage

C = To change information about yourself or a dependent

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked Other Insurance and complete Section 6. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is disabled or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6This section must be completed for all new enrollments or coverage changes.

SECTION 7The employee must sign and date this form in order for it to be processed.

SECTION 8This section is to be completed by the employer's benefit representative.