

ENROLLMENT / CHANGE / CANCELLATION FORM **UnitedHealthcare of Ohio, Inc.** For Plan Use Only:

A. EMPLOYER AUTHORIZATION (FOR EMPLOYER USE ONLY) Date: / /

Group Number: _____ Company Name: _____ Dept. No.: _____ Requested Effective Date: _____ Approved By: _____

B. ACTION (COMPLETE APPLICABLE BOX BELOW) Date: / /

New Enrollment/Additions (check one)

New Hire - Date of Hire: ____/____/____

Open Enrollment: _____

Status Change (PT to FT) on ____/____/____

Return from Leave/Layoff on ____/____/____

Birth (enter child's name and date of birth in Section D)

Marriage on ____/____/____

Adoption (attach legal documentation)

Other (describe) _____

Cancellations (check all that apply)

Cancel all coverage

Cancel dependents listed below - Section D

Reason: (check one)

Death

Divorce

Employee Terminated

Moved out of Service Area

Dependent reached student/depend. maximum age

Other (describe) _____

Change: (check all that apply)

Transfer from Group No. _____ to Group No. _____

Address (enter new address in Section C)

Name (enter new name in Section C or D)

Electing Continuation Coverage

Change in Other Health Insurance Information (complete Section E)

Other (describe) _____

C. EMPLOYEE INFORMATION

Employee Social Security Number: _____

Home Street Address: _____

Home Phone (): _____

Work Phone (): _____

City: _____ State: _____ Zip Code: _____

Country: _____

Marital Status: Single Married

Employee's Company Name/Division: _____

Employee Status: Full Time Part Time Retired

Salaried Hourly Exec.

Bargaining Non-Bargaining

D. FAMILY INFORMATION Employee, Spouse, Dependents to be enrolled, cancelled, changed (attach extra sheet, if needed)

Coverage will not be offered to a dependent living outside the service area, unless he/she is a full-time student or coverage is required by court decree. If you are required by court decree to provide coverage for any dependent, listed below, please attach a copy of the decree.

On the day your coverage begins will any family members be covered by other health insurance, including another UnitedHealthcare policy, or Medicare? **YES** **NO** If yes, complete questions below. (Attach additional sheet, if needed)

Check Appropriate Box	Relationship	First Name	M.I.	Last Name	Sex	Date of Birth (MM/DD/YY)	Social Security Number	Resides with Employee	Other Medical Insurance	Insurance Company Name (if Medicare, Complete below)	Policyholder Name & Policy Number	Policyholder's Employer Name	Policy Coverage Dates
Enroll	EMPLOYEE				M			N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Cancel					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Change					F				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Enroll	SPOUSE				M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Cancel					F				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Change					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Enroll					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Cancel					F				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Change					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Enroll					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Cancel					F				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Change					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Enroll					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Cancel					F				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
Change					M				<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:

E. OTHER HEALTH INSURANCE - Failure to complete this section may result in claims being disallowed until information is provided.

Part A Effective Date: _____ Part B Effective Date: _____

Is Medicare eligibility due to: Kidney failure Disability

F. PRODUCT SELECTION (CHECK ONE) Name of family member: _____ Medicare Claim Number: _____

Non-Network benefits provided by UnitedHealthcare Insurance Company of Ohio.

Coverage Selection: Employee Only Employee + 1 or more Dependents No Medical Coverage

* MUST be checked if coverage is waived

G. SIGNATURE (FORM MUST BE SIGNED FOR ANY ENROLLMENT CHANGE OR CANCELLATION ACTIVITY)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give UnitedHealthcare of Ohio, Inc. 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. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage. **FRAUD WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Employee Signature: _____ Date Signed: ____/____/____

Spouse Signature: _____ Date Signed: ____/____/____

