To speed enrollment process, please be thorough and fill out all sections that apply.

☐ Enroll ☐ Cancel ☐ Change | ☐ Address Change ☐ Name Change Date of Change ___/___/___

A. Employee Information

First Name | M.I. | Last Name | Social Security #/Employee ID #

Street Address | Apt. # | City | County | State | Zip | Country

Home Phone | Work Phone | How many hours do you work per week? | E-mail Address ☐ Home ☐ Work

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Sex ☐ M ☐ F | Birthdate | Height/Weight ____ft. ____in. _____lbs. | Physician* | Physician's ID No. | Are you a current patient? ☐ Yes ☐ No

B. Family Information

Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Last Name First Name M.I. / Dependent Social Security No.	Sex	Birthdate	Relationship**	Height/ Weight	Full-Time Student	Physician* / Physician's ID Number	Are you a Current Patient?
☐ Enroll ☐ Cancel ☐ Change	SS# | | | |–| | |–| | | |	M F				☐ Yes ☐ No School Name:		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | |–| | |–| | | |	M F				☐ Yes ☐ No School Name:		☐ YES ☐ NO
☐ Enroll ☐ Cancel ☐ Change	SS# | | | |–| | |–| | | |	M F				☐ Yes ☐ No School Name:		☐ YES ☐ NO

***IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care), for yourself and each of your covered dependents for UnitedHealthcare Select and Select Plus only. **Legal documentation must be attached for: full-time students age 19 or older; court ordered dependents; and dependents not residing with eligible employees. If dependent does not reside with eligible employee, please provide address on separate sheet.**

C. Product Selection (check all that apply)

MEDICAL BENEFITS:
- ☐ Employee Only Coverage
- ☐ Employee/Spouse Coverage
- ☐ Employee/Children Coverage
- ☐ Employee/Spouse/Children Coverage
- ☐ **No Medical Coverage (complete Section E)**

DENTAL BENEFITS:
- ☐ Employee Only Coverage
- ☐ Employee/Spouse Coverage
- ☐ Employee/Children Coverage
- ☐ Employee/Spouse/Children Coverage
- ☐ No Dental Coverage
- ☐ I decline coverage for myself
- ☐ I decline coverage for my spouse
- ☐ I decline coverage for my children

Reason: ☐ Covered under another plan ☐ Other: _____

LIFE INSURANCE PRODUCTS

Salary $_____ ☐ wk ☐ mo ☐ yr

- ☐ Life/Accidental Death or Dismemberment
- ☐ Dependent Life Insurance
- ☐ Supplemental Life
- ☐ Suppl. Accidental Death and Dismemberment

EMPLOYER USE ONLY

Benefit Level/Class Code

Life Beneficiary's Full Name and Address | Relationship

OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)

☐ UnitedHealthcare Overture Classic ☐ UnitedHealthcare Overture Performance ☐ UnitedHealthcare Overture Premier

D. To Be Completed By Employer

Company Name | Group # | Plan Variation Medical _____ Dental _____ | Department Number

☐ **New Enrollment/Additions: (Check one)** (attach COBRA Election Form)
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption (attach legal documentation)
☐ Court ordered dependent (attach documentation)
☐ Other (describe) _____
☐ COBRA/Continuation start date _____ stop date_____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel listed above – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached student/dependent max age
☐ Other (describe)_____

Product Selections – Check all that apply | ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retired/Date_____

- ☐ UnitedHealthcare Choice Plus
- ☐ UnitedHealthcare Managed Indemnity
- ☐ UnitedHealthcare Select Plus
- ☐ UnitedHealthcare Overture Package: _____ (A-S)
- ☐ UnitedHealthcare Options PPO
- ☐ UnitedHealthcare Options PPO 80/80
- ☐ UnitedHealthcare Rhapsody

DENTAL PLANS
- ☐ UnitedHealthcare Dental Managed Indemnity
- ☐ UnitedHealthcare Dental Options PPO

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section D. 3) Please provide your signature and today's date.

Signature/Employer Position _____ Date _____ Phone # _____

E. Other Medical Coverage Information / Waiver (This section must be completed)

Applicant Name _____

Have you or your dependents had any other medical coverage in the last 12 months? ☐ YES ☐ NO Will this coverage be terminated? ☐ YES ☐ NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date

Coverage type: ☐ Group Policy ☐ Individual Policy ☐ Medicare/Medicaid ☐ Other_____

Is this coverage through your spouse's employer? ☐ YES ☐ NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)

Medicare effective date Parts A&B	Reason for Medicare eligibility: ☐ Over 65 ☐ Disabled ☐ Kidney Disease	Medicare Claim #

WAIVER **I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:**

☐ Existence of other health coverage ☐ Spousal coverage ☐ Other Reason (Explain) _____

Check one of the above boxes, then read and sign.

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 and may apply at next open enrollment period. 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 dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information"located on the back of this form.

X Employee Signature_____ Date Signed_____

(only sign if you are waiving coverage)

Medical History

☐ Yes ☐ No 1. Have your or your dependents visited a health care professional including inpatient or outpatient hospitalization in the past 5 years for any illness, injuries, medical condition or surgery (including mental health, chemical dependency and infertility)? If yes, list person's name, dates, reason for and results of the treatment.

☐ Yes ☐ No 2. Have you or your dependents been prescribed or taken any prescription medications for more than 30 days in the past 12 months? If yes, list person's name, name of drug, reason for prescribing medication and dates taken.

Applicant Name _____

Medical History (continued)

☐ Yes ☐ No 3. Are you or your dependents aware of any condition, illness or injury that may require (ongoing or future) surgery or treatment of any type, or has any surgery or treatment been recommended that has not yet been performed?

☐ Yes ☐ No 4. Are you or your dependents currently pregnant? If yes, list person's name, expected delivery date and any complications including the anticipation of multiple births.

☐ Yes ☐ No 5. Has anyone on this application used tobacco products in the past 12 months?

IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SHEET AND BE SURE TO DATE AND SIGN THAT SHEET.

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate to the best of my knowledge and belief.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date _____ **Employee Signature** _____

Spouse Signature (if possible) and applicable) _____

Email Address _____

CONNECTICUT INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN CONNECTICUT TO SMALL EMPLOYERS OF 1-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.