

Global Insurance Enrollment Application/Change/Cancellation Request



P.O. Box 740111
 Atlanta, GA 30374-0111
 Fax: 877-370-4150

<input type="checkbox"/> Enroll	<input type="checkbox"/> Address Change
<input type="checkbox"/> Cancel	<input type="checkbox"/> Name Change
<input type="checkbox"/> Change	Date of Change ___ / ___ / ___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name		Group #	Department #
Plan Variation Medical _____ Vision _____ Dental _____		Reporting Code Medical _____ Vision _____ Dental _____	
<input type="checkbox"/> New Enrollment/Additions: (Check one) Date of Hire ___ / ___ / ___ If non- U.S. Citizen - Employee Number _____ Requested Date of Coverage ___ / ___ / ___ <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Court ordered dependent <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/State Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___ / ___ / ___		<input type="checkbox"/> 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 Reason: (check one) <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 dependent max age <input type="checkbox"/> Other (describe) _____	
Signature		Date	
Employer Position		Phone	

A. Employee Information

Social Security Number (US only)	Birthdate / / MM DD YYYY	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name	First Name	MI
Assignment Residence Address		Apt#	City/Town	State/Region	Area Postal Code Country
Home Phone		Work Phone		Cell Phone	
Race – Check all that apply (Optional)					
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify					

Preferred Mailing Address Check if same as above

Street Address	Apt#	City/Town	State/Region	Area Postal Code	Country
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Other information:

E-mail Address	Preferred Communication Type: <input type="checkbox"/> E-mail <input type="checkbox"/> Phone <input type="checkbox"/> Mail	Resident of
Language preference if not English	Citizen of	

Coverage provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by UnitedHealthcare Global Company
 Dental coverage provided by UnitedHealthcare Global Company
 Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Global Company or Unimerica Insurance Company
 Vision coverage provided by UnitedHealthcare Global Company

B. Family Information

List All Enrolling/Changing/Canceling (Attach sheet if necessary)

<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner (if eligible)	Birthdate / / MM DD YYYY
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Preferred mailing address	Apt#	City/Town	State/Region	Area Postal Code	Country
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Social Security Number (U.S. only)	Dependent Citizenship Country:	Race – Check all that apply (Optional) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify
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<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Dependent	Birthdate / / MM DD YYYY
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<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Dependent	Birthdate / / MM DD YYYY
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<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Dependent	Birthdate / / MM DD YYYY
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Preferred Mailing address	Apt#	City/Town	State/Region	Area Postal Code	Country
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Social Security Number (U.S. only)	Dependent Citizenship Country:	Race – Check all that apply (Optional) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify
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<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Dependent	Birthdate / / MM DD YYYY
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Preferred Mailing address	Apt#	City/Town	State/Region	Area Postal Code	Country
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Social Security Number (U.S. only)	Dependent Citizenship Country:	Race – Check all that apply (Optional) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify
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* Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their health and well-being and not for eligibility or claim payment determination.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	LTD	Life	ADD	Dual Option Selected
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$_____	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Life Insurance Beneficiary's Full Name and Address	Relationship
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D. Reimbursement options

Pay Member

Use banking details on file Payment by check Electronic funds transfer payment

Specify currency for reimbursement _____ Note - If no selection, reimbursement will default to a US dollar check

For bank transfers please complete the following:

Bank name _____

Bank address _____

SWIFT / BIC Code _____

Beneficiary routing code _____

Account number / IBAN _____

Account name / Payee _____

E. Other Medical or Other Country 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 or country health plan or policy, including another UnitedHealthcare plan or Medicare?

YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier or other country coverage:

Other Group Medical or Other Country Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

* B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (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.

E. Waiver of Coverage

I decline coverage for:

- Myself
- Spouse
- Domestic Partner
- Dependent Children
- Myself and all dependents

Declining coverage due to existence of other coverage:

- Spouse's Employer's Plan Individual Plan
- Covered by Medicare Medicaid
- COBRA from Prior Employer VA Eligibility
- Tri-Care
- I (we) have no other coverage at this time
- Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included

Employee Initials	Date
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F. Signature

I confirm that the information I have provided on this form is complete and accurate.

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. 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 for all applying and waiving	Spouse Signature (if applying for coverage) (Spouse may include a Domestic Partner, depending on your benefit plan)
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IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

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 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.