Enrollment/Change Form

Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:
Employer Authorization:	Date of Hire: ___/___/___	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: _____/_____/_____		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)	☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
	☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Birth
	☐ Divorce	☐ Dissolution Of Domestic Partnership	☐ Death	☐ Declaration of Domestic Partnership*
	☐ Adoption/Legal Custody	☐ Court Ordered Dependent	☐ Cobra/State Continuation	
	☐ Other:		Start Date ___/___/___ End Date ___/___/___	

EMPLOYEE INFORMATION

SS# ____________-________-________________	Employer Assigned ID# ___________	Date of Birth: ___/___/_________
Last Name:	First Name:	Middle Initial:
Address:	City: State:	Zip Code:
Home Phone: Work Phone:	Email Address:	Annual Salary: $
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner *	

Number of hours worked per week: _____________

Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

FAMILY INFORMATION

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

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No

* A Domestic Partnership is established when both persons have filed a Declaration of Domestic Partnership with the State of California. Please contact your employer for confirmation.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

BENEFIT ELECTIONS				
Person	**Basic Life**	**Basic AD&D**	**STD**	**LTD**
Employee Spouse (or Domestic Partner) Dependent	☐ $_____ ☐ $_____ ☐ $_____ ☐ Waive (if applicable)	☐ $_____ ☐ Waive (if applicable)	☐_____ ☐ Buy-up ☐ Waive (if applicable)	☐_____ ☐ Buy-up ☐ Waive (if applicable)

Person	Supplemental Life	Supplemental AD&D
Employee Spouse (or Domestic Partner) Dependent	☐$_____ ☐$_____ ☐$_____ ☐ Waive Have you used tobacco of any kind in the past 12 months? Employee? ☐Yes ☐No Spouse? ☐Yes ☐No	☐ $_____ ☐ $_____ ☐ $_____ ☐ Waive

BENEFICIARY(IES)*	Beneficiary(ies) to be designated at time of Enrollment.						
Product	**Full Name**	**%**	**Address**	**City**	**State**	**Zip Code**	**Relationship**
Life & AD&D	Primary						
	Secondary/ Contingent						

* Do not use to change a previously designated Beneficiary. For changes, use the Beneficiary Designation form available from the Employer.

AUTHORIZATION AND ACKNOWLEDGEMENT **Form must be signed**

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

Employee/Enrollee Signature:	Date:

FRAUD WARNING NOTICE **Please review the following notice.**

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.