

Employee Enrollment Form for an Association Health Plan



Illinois

Please fill out the entire enrollment form to avoid processing delay.
Please clearly print all information.

- UnitedHealthcare Insurance Company
- UnitedHealthcare Insurance Company of Illinois
- UnitedHealthcare of Illinois, Inc.
- UnitedHealthcare Insurance Company of the River Valley
- UnitedHealthcare Plan of the River Valley, Inc.

Association Health Plan Name:		
Group/Policy #	Employer Name	Requested Effective Date of Coverage / Date of Change

Employer Address (if more than one location)

Employee Type (check all that apply): <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation Start date ____/____/____ End date ____/____/____ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	Reason for Application / Change Request (check all that apply): <input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption or Placement for Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of other coverage (employee or dependent) <input type="checkbox"/> Termination <input type="checkbox"/> Returning to School Full Time <input type="checkbox"/> Other _____ Date of Event: _____ (You may be required to provide proof of event.)
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Enrollee Information

Enrollee Social Security Number		Last Name		First Name		Initial
Address				City	State	Zip Code
Date of Birth		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work () -	
Height	Weight	Email Address				
Date of Hire		Hours Worked Per Week	Occupation		Are you an independent contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Enrollee and Dependent Information (Only for those applying.)

If you need to list additional dependents, please use lined paper, sign and date it, and check this box.

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Middle Initial					
Last Name					
Gender		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth					
Social Security Number					
Height/Weight					
Primary Care Physician's Name	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician's ID number					

Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.

Dental coverage provided by UnitedHealthcare Insurance Company or Dental Benefit Providers of Illinois, Inc.

Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company

Vision coverage provided by UnitedHealthcare Insurance Company

Enrollee Name: _____

Coverage Selection Please check the box for each coverage you or your dependents are enrolling in. If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Enrollee	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____

Person	STD	STD Buy Up	LTD	LTD Buy Up	Salary \$ _____ Required only if Life, STD, or LTD based on salary
Enrollee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	

Life Insurance Beneficiary (if applying for Life Insurance with UnitedHealthcare)

	Full Name and Address	Relationship
Primary		
Secondary		

Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)

	Enrollee	Spouse	Child 1	Child 2	Child 3
Currently Working Full Time	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Plan to Keep Other Insurance Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare / Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Medicare/Medicaid Coverage Effective Date					

Prior Medical Coverage Information

Yes No Have you or any dependents applying for coverage previously had coverage under your employer's group health plan?

If Yes:

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date _____ Effective Date _____ Reason for Termination _____

Type of Plan: Prior Employer Group Plan Spouse's Employer Group Plan Individual Policy

Other _____

Enrollee Name: _____

Signature

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows: I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I declare all statements contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 90 days that was provided to the Association Health Plan (AHP), are true and correct and that no material information has been withheld or omitted. I understand and agree that the AHP is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Plan Documents. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in rescission of the AHP coverage, termination of such coverage, an increase in the payment amount retroactive to the coverage date, or other consequences as permitted by law.

All pages must be attached and complete, including this authorization, for the enrollment form to be considered complete. Incomplete enrollment forms may be rejected.

Enrollee Signature _____ Date _____

Waiver (Please complete if you are waiving medical coverage.)

I waive medical coverage for:

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

Please state reason for waiving coverage:

- Existence of other Qualifying Coverage _____
- Other reason _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Enrollee Signature _____ Date _____

Health Addendum to Employee Enrollment form for Association Health Plans



Illinois

Enrollee Name: _____ SSN: _____

Medical History

Please answer completely and truthfully. Please note that if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective. All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.

United Healthcare Services, Inc. is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Has anyone on this enrollment form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below.

1 Cancer/Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate <input type="checkbox"/> Other Cancer <input type="checkbox"/> Non-Malignant Tumor – Location of Tumor _____
2 Heart / Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Other _____
3 Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date _____ if multiples #____) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Fibroids <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
4 Intestinal / Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Other _____
5 Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Other _____
6 Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS <input type="checkbox"/> Psoriasis <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Immuno Deficiency <input type="checkbox"/> Other _____
7 Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other _____
8 Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Other _____
9 Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
10 Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/Chronic Fatigue Syndrome <input type="checkbox"/> Chronic Pain Syndrome <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other _____
11 Behavioral Health <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar Depression <input type="checkbox"/> Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpatient Alcohol/Drug <input type="checkbox"/> Inpatient Mental Health Hospital <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other _____
12 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications <input type="checkbox"/> Other _____
13 Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Condition not mentioned above with claims in excess of \$5,000 <input type="checkbox"/> Disability <input type="checkbox"/> Congenital Disorder
14 Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anyone on this enrollment form used tobacco products in the past 12 months: Person _____
15 Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications: Person _____ # of Meds ____ Person _____ # of Meds ____ (list meds below) <input type="checkbox"/> Medications taken within the past 12 months: Person _____ # of Meds ____ Person _____ # of Meds ____ (list meds below)

