

Enrollment Application and Change Form

- Choice Plus Health Plan
 HSA Health Plan

UnitedHealthcare®

| EMPLOYEE INFORMATION | | | | | | | |
|---------------------------|------------|-------------------|--|--|---|--|---|
| Last Name | First Name | MI | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | Social Security Number | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | |
| Home Address | | City | | State | Zip Code | Home Phone Number () () | |
| Employer Name | | Division/Location | | <input type="checkbox"/> FT <input type="checkbox"/> PT | <input type="checkbox"/> Union <input type="checkbox"/> Nonunion | <input type="checkbox"/> Hourly <input type="checkbox"/> Salary | <input type="checkbox"/> Active <input type="checkbox"/> Retired (Date) () |
| Work Phone Number () () | | | | | | | |

WHO SHOULD BE COVERED

Employee Only
 Employee Plus Spouse
 Employee Plus One Dependent
 Employee Plus Child(ren)
 Employee Plus Family

WAIVER OF COVERAGE

I decline coverage for myself
 I decline coverage for my dependents

Reason: covered under another plan
 Other: _____
(See sections 6&7)

**Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.*

TYPE OF CHANGE

Add Spouse/Child (complete Sec. 5)
 Terminate Spouse/Child (complete Sec. 5)
 Address (enter above)
 Name Change (complete Sec. 5)
 Terminate All Coverage - Reason _____

Reinstatement - Reason _____
 Surviving Spouse - Former Employee SSN _____
 COBRA Continuee - Former Employee SSN _____
 Other _____

EFFECTIVE DATE: _____

| COVERAGE INFORMATION | | | | | | | | | |
|--------------------------------|-----------|------------|----|-------------------|--------------------------|--|--|--|--|
| (A) Add (T) Term (C) Chg | Last Name | First Name | MI | Social Security # | Date of Birth (MM/DD/YY) | Sex | Other Insurance | Disabled | Full-Time Student Over 19? |
| | Employee | | | | | | | | |
| | Spouse | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| | Child 1 | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Child 2 | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Child 3 | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |

OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another United HealthCare plan, Medicare or Medicaid?..... Y N
 Is another person legally responsible for coverage for your children?..... Y N
 If you answered yes to either of the questions above, please complete the following:

| | | |
|--|-----------------------|---------------------------------------|
| Person's Name with Other Health Plan | | Social Security Number |
| Date of Birth | Sex | Other Company's Name and Phone Number |
| Other Company's Policy Number and Effective Date | | |
| Medicare Number | Part A Effective Date | Part B Effective Date |

AUTHORIZATION

On behalf of myself anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates (and the employer) 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. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employee's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.

NOTICE OF ENROLLMENT RIGHTS
 I understand that if I and/or my dependent, 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. 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 10 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Health Insurance or medical services benefits provided or administered by United HealthCare Insurance Company, Minneapolis, MN.

Signature _____

Date _____