

**Incomplete information will delay the processing of coverage**

**ENROLLMENT/CHANGE FORM**  
PLEASE SELECT:  ENROLLMENT  CHANGE

**A. TELL US ABOUT YOURSELF** Current United HealthCare ID #, if any \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Number and Street \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone (\_\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_\_) \_\_\_\_\_

Marital Status:  Single  Married  Divorced

Company Name \_\_\_\_\_

Do you speak another language?  Yes  No

If Yes \_\_\_\_\_

**YOU ARE APPLYING FOR:**

Single Medical  
 Emg. + 1 Medical  
 Emg. + Children Medical  
 Family Medical  
 Single Dental  
 Emg. + 1 Dental  
 Emg. + Children Dental  
 Family Dental

**YOUR BENEFIT CHOICES - UNITED HEALTHCARE**

Direct Access  
 Choice Plus HMO  
 Choice HMO  
 Select: HMO  
 Select: Plus HMO  
 Dental  
 Other \_\_\_\_\_

**PLEASE CHECK BOXES THAT APPLY**

**WAIVER OF COVERAGE** The reason I am not applying for medical coverage is:  
 Covered by spouse's group medical plan: \_\_\_\_\_ (name of carrier)  
 Other (please explain): \_\_\_\_\_

**TRANSFER: FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

**NEW MEMBERSHIP:**  
 Annual Renewal 103/123  
 New Hire 104/124  
 COBRA 219

**DELETIONS:**  
 Cancel All Coverage  
 Cancel Medical Only 204  
 Delete Dependents

**ADDITIONS:**  
 Add Medical 203  
 Add COBRA Coverage 219  
 Add Dependents  
 Other: \_\_\_\_\_

**REASON:**  
 Employee Termination 321  
 Non-payment 301  
 Member Request 323  
 Layoff 302  
 Non-election of COBRA 326  
 Other: \_\_\_\_\_ 324

**CHANGES (Check all that apply)**  
 Change Primary Care Physician (Complete Section B)  
 Change Employee Address/Name (Complete Section A)  
 Change Beneficiary for Life Benefit (if offered)  
Change Beneficiary to: \_\_\_\_\_ Relationship: \_\_\_\_\_

**QUALIFYING EVENTS: Attach supporting documentation for all qualifying events other than birth.**  
 Birth 126  Full-time Student 101/121  Loss of coverage 101/121  Return from layoff 107/125  
 Marriage 101/121  Common Law 101/121  Other: \_\_\_\_\_

**TO BE COMPLETED BY EMPLOYER**

Group #: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Dept. Code: \_\_\_\_\_

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

**REASON FOR ENROLLMENT**  
 New Group  New Hire  
 COBRA  Late Enrollee  
 Open Enrollment  
Reason for change: \_\_\_\_\_

**B. TELL US ABOUT YOUR OTHER INSURANCE**

Are you or any other family member covered with any other medical coverage?  
 Yes  No If yes, please fill out below.

Name of other insurance company: \_\_\_\_\_

Name of subscriber (policy holder): \_\_\_\_\_ Policy or ID #: \_\_\_\_\_

**E. MEDICARE**

Is this person a retiree?  Yes  No

Medicare #: \_\_\_\_\_ Effective Dates: \_\_\_\_\_ Medicare A: \_\_\_\_\_ Medicare B: \_\_\_\_\_

Do you or any covered family member have Medicare?  Yes  No

Name: \_\_\_\_\_

**C. IF APPLICABLE**

Life Benefit  Accidental Death and Dismemberment  Weekly Accident and Sickness Benefits

The ancillary product benefit(s) requested in this section are not effective until purchased by your employer and approved by Metropolitan Life Insurance Company.

**TO BE COMPLETED BY EMPLOYER**

Contributory  Non-Contributory

If available, do you want dependent life coverage:  Yes  No

Your Beneficiary's Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**D. MEMBERS TO BE COVERED**

Employee Name	Spouse's Name	Dependents - Full Time Student Age 19 or Over (Attach Proof)	Sex (circle one)	Date of Birth (Must be completed)	Social Security Number (Must be completed)	PRIMARY CARE PHYSICIAN (If choosing a Select Plan)	PCPP# (If choosing a Select Plan)	Are you a regular patient of this doctor?
00	01	02	M	-	-	Last _____ First _____ Town/City _____		Y
		03	F	-	-			N
		04	M	-	-			N
		05	M	-	-			N

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION:** On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give United HealthCare Insurance Company, United HealthCare of New England, Inc. 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 statement made on this application may invalidate my and/or my dependents' coverage. I understand that this change will become effective only on the date specified by the insurer after the change has been approved by the insurer and after the full premium resulting from any change has been paid. By signing this change application form, I hereby certify that all the information provided is true and correct.

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. 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption.

**EMPLOYEE SIGNATURE X:** \_\_\_\_\_ **DATE** \_\_\_\_\_

\* Self-funded groups only