

**Enrollment/Change/Cancel Form**

- PPO     State Continuation
- COBRA

<b>FOR PLAN USE ONLY</b>	Date Entered	Processor	Rate Class	Eff. Date
<b>EMPLOYER TO COMPLETE</b>	Employer Name		Group Number	Dept #
Authorized Employer Signature			Date / /	Employee Hire Date / /

**A. ACTION (Complete Applicable Box Below)**

<p><b>New Enrollment/Additions</b> (check one)</p> <input type="checkbox"/> New Hire – Date of Hire: ____/____/____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Status Change (PT to FT) on ____/____/____ <input type="checkbox"/> Return from Leave/Layoff: ____/____/____ <input type="checkbox"/> Birth--enter child's name and birthdate below <input type="checkbox"/> Marriage on ____/____/____ <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Other (describe) _____ Requested Effective Date of Enrollment ____/____/____	<p><b>Cancellations</b> (check all that apply)</p> <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel dependents listed below – in Section C 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 maximum age <input type="checkbox"/> Other (describe) _____ Requested Effective Date of Cancellation ____/____/____	<p><b>Change</b> (check all that apply)</p> <input type="checkbox"/> Transfer from Group No. _____ To Group No. _____ <input type="checkbox"/> Address (enter new address in Section B) <input type="checkbox"/> Name (enter new name in Section B or C) <input type="checkbox"/> Electing Continuation Coverage <input type="checkbox"/> Change in Other Health Insurance Information (complete section E) <input type="checkbox"/> Other (describe) _____ Requested Effective Date of Change ____/____/____
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**B. EMPLOYEE INFORMATION**

Social Security Number	First Name	M.I.	Last Name	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Street Address	City	State	Zip Code	
Home Phone ( )	Work Phone ( )	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /	County
Employer Name	Employment status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			

**C. FAMILY INFORMATION List all family members to be covered. Use additional paper, if necessary.**

Check One	Relation to Employee	First Name	M.I.	Last Name	Social Security #	Full-Time Student	Sex	Birth Date
Enroll	Spouse						<input type="checkbox"/> M <input type="checkbox"/> F	
Change								
Cancel								
Enroll						<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> M <input type="checkbox"/> F	
Change								
Cancel								
Enroll						<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:	<input type="checkbox"/> M <input type="checkbox"/> F	
Change								
Cancel								

**D. COVERAGE SELECTION**

**MEDICAL BENEFITS:**

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Medicare Wrap	* If coverage is waived, please check one of the "No Coverage" boxes at left and complete the "Waiver of Coverage" section on the back of this form.
<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> No Employee Coverage *	
<input type="checkbox"/> Employee + Child (ren)	<input type="checkbox"/> No Dependent Coverage *	
<input type="checkbox"/> Family Coverage		

**E. OTHER HEALTH INSURANCE INFORMATION (This section must be completed)**

On the day your coverage begins will any family members, including those not listed above, be covered by other health or dental insurance, Medicare or Medicaid?  YES     NO    If yes, complete section E. on the back of this form.

**F. SIGNATURE (This form must be signed)**

**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 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 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. The information provided on this application is accurate and complete. **If you have any questions concerning benefits and services provided by or excluded under this agreement, please contact the Insurance Company's Customer Service Department before signing this application.**

X	X
Employee Signature	Spouse Signature
Date Signed	Date Signed

First Name	M.I.	Last Name	Date	Social Security Number
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**WAIVER OF COVERAGE**

I have been given the opportunity to apply for group medical coverage. I hereby waive coverage for:  Myself  My spouse  My Dependent children. Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, please check this box: . You may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. *(Stop here and sign and date form).*

**E. OTHER HEALTH INSURANCE INFORMATION**

This section MUST be completed if you checked "Yes" (on the front of this form) to indicate you or your family members will have other health coverage on the day this coverage takes effect. Use extra paper if more than one policy will be in force.

Coverage Type: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Medicare	Insurance Company Name, Address and Phone Number		Policy Number	
Policy Coverage Dates to	Name of Policyholder	Policyholder's Birth date	Family Members Covered	
Policyholder's Employer Name, Address & Phone Number				
Names of family members covered by Medicare	Medicare Claim Number	Part A Effective Date	Part B Effective Date	Is Medicare eligibility due to <input type="checkbox"/> Kidney failure <input type="checkbox"/> Disability

**The completed Enrollment/Change/Cancel Form should be mailed to:**

**United HealthCare of the Mid-Atlantic  
P. O. Box 1459  
Mail Route MN002-0232  
Minneapolis, MN 55440-1459**

**Fax Number: 952-833-6526**

**Telephone Number: (Toll Free) 877-644-4315**