(DO NOT STAPLE)

Employee Enrollment Form
Minnesota

UnitedHealthcare®

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed By Employer | **Requested Effective Date of Coverage/Date of Change** / /

Group Name | Policy Number

Date of Hire

Position/Title

Hours Worked per week

Salary $ _____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ Life Event/Date _____
- ☐ Status Change _____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Part time to Full time
- ☐ Waiving Coverage
- ☐ Other _____
- ☐ New Hire
- ☐ Annual Open Enrollment
- ☐ Late Enrollee
- ☐ Termination

Employee Type (Check all that apply)
- ☐ Active ☐ COBRA ☐ State Continuation
  - Start dt ____/____/____
  - End dt ____/____/____
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and B.

Last Name | First Name | MI | Social Security Number[1]

Address | Apt # | City | State | Zip Code | Home Phone | Cell Phone | Work Phone

Date of Birth / / | Sex ☐ M ☐ F | Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed | Language Preference, if not English _____

Email Address:

Do you use tobacco?[2] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[3] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name _____

Address _____

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[4]

Dentist First & Last Name _____

ID# _____

Existing Patient? ☐ Yes ☐ No

B. Waiver of Coverage

I decline all coverage for:
- ☐ Myself
- ☐ Spouse
- ☐ Dependent Children
- ☐ Myself and all dependents

Declining coverage due to existence of other coverage:
- ☐ Spouse's Employer's Plan
- ☐ Covered by Medicare
- ☐ COBRA from Prior Employer
- ☐ Tri-Care
- ☐ I (we) have no other coverage at this time
- ☐ Other _____
- ☐ Individual Plan
- ☐ Medicaid
- ☐ VA Eligibility

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date | Employee Signature if waiving all coverage

[1]Your Social Security number (SSN) is requested to identify you and your family and to report your coverage status to the federal government. The IRS requires UnitedHealthcare to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS or UnitedHealthcare, asking you to verify your SSN for tax purposes. [2]Tobacco means all tobacco products, including, but not limited to, cigarettes,cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. Only individuals age 21 and older are required to answer this question. [3]For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. [4]Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Illinois, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name ____________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[5]	Last Name	First Name	MI	Sex	Date of Birth
Spouse /Domestic Partner				☐M ☐F	/ /
	Social Security Number[1] __ __ __ — __ __ — __ __ __ __	Do you use tobacco?[2] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[3] Existing Patient? ☐Yes ☐No

Physician First & Last Name ____________________

Address ____________________

ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[4] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ____________________

ID# ____________________

Relationship[5]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number[1] __ __ __ — __ __ — __ __ __ __	Do you use tobacco?[2] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[3] Existing Patient? ☐Yes ☐No

Physician First & Last Name ____________________

Address ____________________

ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[4] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[6] ☐Yes ☐No

Relationship[5]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number[1] __ __ __ — __ __ — __ __ __ __	Do you use tobacco?[2] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[3] Existing Patient? ☐Yes ☐No

Physician First & Last Name ____________________

Address ____________________

ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[4] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[6] ☐Yes ☐No

Relationship[5]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number[1] __ __ __ — __ __ — __ __ __ __	Do you use tobacco?[2] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[3] Existing Patient? ☐Yes ☐No

Physician First & Last Name ____________________

Address ____________________

ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[4] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ____________________

ID# ____________________

Permanently disabled and age 26 or older[6] ☐Yes ☐No

[1]Your Social Security number (SSN) is requested to identify you and your family and to report your coverage status to the federal government. The IRS requires UnitedHealthcare to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS or UnitedHealthcare, asking you to verify your SSN for tax purposes. [2]Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. Only individuals age 21 and older are required to answer this question. [3]For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. [4]Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. [5]For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. [6]If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Employee Name _____

D. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
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
Employee	☐ _____	☐ _____	☐	☐$_____	☐$_____
Spouse/Domestic Partner	☐	☐	☐	☐$_____	☐$_____
Dependent	☐	☐	☐	☐$_____	☐$_____

Person	STD	LTD
Employee	☐	☐

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)	Relationship
Primary	
Secondary	

E. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___ / ___ / ___ End date ___/___/___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

F. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___/___ / ___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

G. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

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:

DISCLAIMER

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, 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 recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents.

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 authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, is valid as long as the individual is continually insured with UnitedHealthcare.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify _____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- **Online:** UHC_Civil_Rights@uhc.com
- **Mail:** Brad Johnson. Director, Regulatory Affairs. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- **Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- **Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- **Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call toll-free [888-383-9253].

You have the right to get help and information in your language at no cost. To request an interpreter, call [insert number here], press 0. TTY 711

1	Spanish	Tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para solicitar un intérprete, llame al [insert number here] y presione el cero (0). TTY 711
2	Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu rau [insert number here], nias 0. TTY 711
3	Cushite	Kaffaltii alla afaan keessaniin odeeffannoo fi deeggarsa argachuuf mirga ni qabdu. Nama afaan hikuu argachuuf, lakkoofsa bilbilaa [insert number here] tiin bilbilaa. 0 Tuqii. TTY 711
4	Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi [insert number here], bấm số 0. TTY 711

5	Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [insert number here]，再按 0。聽力語言殘障服務專線 711
6	Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по телефону [insert number here] и нажмите 0. Линия TTY 711
7	Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ, ໃຫ້ໂທຫາ [insert number here], ກົດເລກ 0. TTY 711
8	Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ[insert number here]ይደውሉና 0ን ይጫኑ። TTY 711
9	Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးန့ါဘဉ်တါ်မၤစၢးဒီးတါ်ဂ့ါတါ်ကျိုၤလၢနကျိာ်ဇဉ်နဝဲလၢတလိဉ်ဟ့ဉ်အပူၤဘဉ်နူဉ်လီၤ.လၢတါ်ကဃ့နူ်ပှၤကတိၤကျိးထံတါ်တဂၤအဂီၢ်ကိးဘဉ် [insert number here],ဆိဉ်လီၤနီၢ်ဂ်ၢ် 0 တက့ါ်. TTY 711
10	German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die Nummer [insert number here] an und drücken Sie die 0. TTY 711
11	Mon-Khmer, Cambodian	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមហៅលេខ [insert number here] រួចហើយ ចុចលេខ 0។ TTY 711
12	Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل بالرقم [insert number here]، واضغط على 0. الهاتف النصي (TTY) 711
13	French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le [insert number here] et appuyez sur la touche 0. ATS 711.
14	Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 [insert number here]로 전화하여 0번을 누르십시오. TTY 711
15	Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tumawag sa [insert number here], pindutin ang 0. TTY 711