(DO NOT STAPLE)

CALIFORNIA

Small Business Employee Enrollment Form

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

UnitedHealthcare®

UnitedHealthcare Insurance Company
UnitedHealthcare of California
UnitedHealthcare Benefits Plan of California

To Be Completed by Employer	Group Name/Number	
Requested Effective Date of Insurance / Health Plan Coverage / Date of Change / /	Reason for Application ☐New Group Plan ☐New Hire ☐Dependent Add/Delete ☐Annual Open Enrollment ☐Change Name/Address ☐Late Enrollee ☐Termination Date:___/___/___ ☐Waiving Coverage (Complete Sections A and E) ☐Life Event/Date_____ ☐Status Change _____ ☐Other _____	Employee Type (check all that apply) ☐Active ☐Union ☐Non-Union ☐Retired ☐Hourly ☐Salary ☐Other ☐COBRA ☐Cal-COBRA Start Date __/__/__ End Date __/__/__ Indicate Qualifying Event_____ Original Qualifying Event Date Start Date __/__/__ End Date __/__/__
Date of Hire / /		
Position/Title		
Hours Worked Per Week		

A. Employee Information

Complete All Sections
If you are waiving coverage, please complete only Sections A and E

Last Name	First Name	MI	Social Security Number	Home Phone/Cell Work Phone

Address	Apt #	City	State	ZIP Code	Email Address

Date of Birth / /	Sex ☐M ☐F	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner	Have you or your dependents ever been a UnitedHealthcare member? ☐Yes ☐No

Preferred Language: ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____

Primary Care Physician[1] Name: _____ Address _____ ID# Existing Patient Medical ☐Yes ☐No	Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No

B. Dependent Information

List All Enrolling (attach sheet if necessary)

Name (Last, First, M) Social Security Number I I I I – I I I – I I I I	Sex ☐M ☐F	Relationship[3] Spouse/ Domestic Partner	Date of Birth _____/_____/_____
Address (if different from Employee)	Preferred Language ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____		
Primary Care Physician[1] Name: _____ Address: _____ ID# Existing Patient Medical ☐Yes ☐No	Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No		

Name (Last, First, M) Social Security Number I I I I – I I I – I I I I	Sex ☐M ☐F	Relationship[3] Dependent	Date of Birth _____/_____/_____
Address (if different from Employee)	Please check box when selecting HMO health plan coverage: Permanently disabled and age 26 or older[4] ☐Yes ☐No Preferred Language ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____		
Primary Care Physician[1] Name: _____ Address: _____ ID# Existing Patient Medical ☐Yes ☐No	Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No		

IMPORTANT: (1) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) For court-ordered dependent, legal documentation must be attached. (4) Applicable to HMO health plan coverage selection: 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.

Subscriber Last, First Name_____ **SSN** _____

B. Dependent Information (continued)

Name (Last, First, M)	Sex	Relationship[3]	Date of Birth
Social Security Number I I I I – I I I – I I I I I	☐M ☐F	Dependent	_____/_____/_____

Address (if different from Employee)

Please check box when selecting HMO health plan coverage:
Permanently disabled and age 26 or older[4] ☐Yes ☐No

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese
☐Korean ☐Other _____

Primary Care Physician[1] Name: _____
Address: _____
ID# Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: _____
ID#: _____
Existing Patient Dental ☐Yes ☐No

Name (Last, First, M)	Sex	Relationship[3]	Date of Birth
Social Security Number I I I I – I I I – I I I I I	☐M ☐F	Dependent	_____/_____/_____

Address (if different from Employee)

Please check box when selecting HMO health plan coverage:
Permanently disabled and age 26 or older[4] ☐Yes ☐No

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese
☐Korean ☐Other _____

Primary Care Physician[1] Name: _____
Address: _____
ID# Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: _____
ID#: _____
Existing Patient Dental ☐Yes ☐No

C. Product Selection

Please check the box for each plan you or your dependents are enrolling in. Benefit offerings are dependent on employer selections.

Person	Medical	Dental	Vision	**Medical Plan and Dental Plan Selection** – Write in the Plan Code or Description of Medical and Dental plan in which you wish to enroll.
Employee	☐	☐	☐	Medical Plan Code/Description:
Spouse/Domestic Partner	☐	☐	☐	Dental Plan Code/Description:
Dependents	☐	☐	☐	

D. Other Medical Insurance/Health Plan Coverage Information

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

On the day this insurance/health plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical insurance/health plan coverage, including another UnitedHealthcare plan or Medicare?

☐YES (continue completing this section) ☐NO (If NO, then skip the rest of the Other Medical Insurance/Health Plan Coverage section.)

Name of other carrier _____

Other Group Medical Insurance/Health Plan 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/covered employee for other insurance/health plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

†B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (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.

Coverage provided by "UnitedHealthcare and Affiliates":
Check appropriate box(s) for coverage(s) selected:
Medical ☐ UnitedHealthcare Insurance Company or ☐ UnitedHealthcare Benefits Plan of California (Insurance Products: Navigate, Choice/Select, Choice Plus/Select Plus, Core, Non-Diff, Doctors Plan)
Medical ☐ UnitedHealthcare of California (HMO)
Dental ☐ UnitedHealthcare Insurance Company or ☐ Dental Benefit Providers of California, Inc.
Vision ☐ UnitedHealthcare Insurance Company
Administrative services provided by United Healthcare Services, Inc., OptumRx, Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Subscriber Last, First Name_____ **SSN** _____

D. Other Medical Insurance/Health Plan Coverage Information (continued)

If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):

Medicare – Employee/Spouse/Domestic Partner/Dependent Name: _____

Medicare ID# _____ (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)
☐ Disabled ☐ Disabled but actively at work

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_____/_____/_____

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

E. Waiver of Coverage

Complete only if you are waiving coverage for yourself and/or any family member.

I decline all coverage for:	Medical	Dental	Vision
Myself	☐	☐	☐
Spouse/Domestic Partner	☐	☐	☐
Dependent Children	☐	☐	☐
Myself and all dependents	☐	☐	☐

Declining coverage reason:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ COBRA/ Cal-COBRA AB1401 from Prior Employer
☐ California Health Benefit Exchange
☐ Covered by Medicare ☐ Medicaid ☐ Tri-Care
☐ VA Eligibility ☐ I (we) have no other coverage at this time
☐ Other _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have been given the right and have been given the chance to apply for coverage. I have decided not to enroll myself and/or my dependent(s), if any.

I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in my employer health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THE GROUP MEDICAL PLAN. THE WAIT OF UP TO TWELVE (12) MONTHS WILL NOT APPLY IF I AND/OR MY DEPENDENTS ARE ENTITLED TO AN OFF-CYCLE ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.)**

The wait of up to twelve (12) months will not apply if:

1. I certify at the time of initial enrollment that the coverage under another employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, and I lose coverage under that employer health benefit plan, Healthy Families Program, Access for Infants and Mothers (AIM) Program, Covered California, California's Health Benefit Exchange; or no share-of-cost Medi-Cal;
2. My employer offers multiple health benefit plans and I elected a different plan during an open enrollment period;
3. A court orders that I provide coverage under this plan for a spouse or child;
4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 60 days after the marriage, domestic partnership, birth, adoption or placement for adoption;
5. I or my eligible dependents lose health care coverage due to a qualifying event such as loss of employment for any reason other than gross misconduct, reduction of employment hours, death or entitlement to Medicare.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 60 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage. (See Late Enrollment section of Evidence of Coverage and Disclosure Form).

Employee Signature (only if waiving coverage for self and/or dependents)	Date _____/_____/_____

Subscriber Last, First Name_____ **SSN** _____

F. Application Signature

I understand that I am completing a health application and, to the best of my knowledge, that each response is 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) 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 maintain a copy of this authorization for your records.

Please note that if UnitedHealthcare can demonstrate you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare may rescind your coverage. UnitedHealthcare will issue a written notice via regular certified mail at least 30 days prior to the effective date of the rescission explaining the basis for the decision of rescission and your appeal rights. No agreement /policy will be rescinded after 24 months following the issuance of the agreement/policy. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare may cancel your coverage, as permitted by law.

Employee Signature (if applying for coverage)	Employee Name (please print)	Date _____/_____/_____

G. Census Information

NOTE: 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 ☐Native Hawaiian/Pacific Islander ☐Hispanic/Latino
☐American Indian/Alaska Native ☐Asian ☐Other Race, please specify _____

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.