Employee Enrollment Form
Arizona

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

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

Date of Birth / /

Sex ☐ M ☐ F ☐ U

Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Language preference, if not English _____

Email Address:

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

To select paperless delivery complete and sign the enrollment form and provide your email address.
Check here to receive your required plan communications by mail ☐

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
- ☐ Individual Plan
- ☐ Covered by Medicare
- ☐ Medicaid
- ☐ COBRA from Prior Employer
- ☐ VA Eligibility
- ☐ Tri-Care
- ☐ I (we) have no other coverage at this time
- ☐ Other _____

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

Coverage provided by "UnitedHealthcare and Affiliates":
Check appropriate box(es) for coverage(s) selected:
Medical ☐ UnitedHealthcare of Arizona, Inc. (HMO)
Medical ☐ UnitedHealthcare Insurance Company (PPO/Insurance)
Dental ☐ UnitedHealthcare Insurance Company
Vision ☐ UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance ☐ UnitedHealthcare Insurance Company

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[5]	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
Spouse /Domestic Partner	Social Security Number	Do you use tobacco?[1] ☐ 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

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Relationship[5]	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
Dependent	Social Security Number	Do you use tobacco?[1] ☐ 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

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Relationship[5]	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
Dependent	Social Security Number	Do you use tobacco?[1] ☐ 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

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Relationship[5]	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
Dependent	Social Security Number	Do you use tobacco?[1] ☐ 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

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Employee Name _____

C. Family Information (continued)

List all enrolling (attach sheet if necessary)

Relationship[5] Dependent	Last Name	First Name	MI	Sex ☐M ☐F ☐U	Date of Birth / /
	Social Security Number	Do you use tobacco?[1] ☐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

Race/Ethnicity – Check all that apply[2] ☐Prefer not to answer ☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other–Please specify

ZIP code

(1) 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. (2) Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination. (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.

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:

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, by participating in the plan I hereby acknowledge and accept that 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 agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. 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 and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

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 agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize UnitedHealthcare 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. The term "UnitedHealthcare and affiliates" includes the following depending upon the coverage selected: Medical Coverage provided by UnitedHealthcare of Arizona, Inc. (HMO) or UnitedHealthcare Insurance Company (PPO/Insurance). Dental Coverage provided by UnitedHealthcare Insurance Company. Vision Coverage provided by UnitedHealthcare Insurance Company. Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance provided by UnitedHealthcare Insurance Company. 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, expires 30 months after the date it is signed.

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.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health or health-related procedures, products and services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

Please maintain a copy of this authorization for your records.

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