

# LARGE MEMBER ENROLLMENT/CHANGE FORM

Insurance Products provided by

**UnitedHealthcare**  
Insurance Company

\*\*DHMO benefits provided by Dental Benefit Providers of Illinois, Inc.

- PLATINUM BUY-UP - (Payroll ded for EE cov)
- GOLD - (No cost for EE cov)
- SILVER - (No cost for EE cov)

## A. EMPLOYEE INFORMATION

First Name		M.I.		Last Name		Social Security #		Birthdate	
Street Address				Apt. #		<input type="checkbox"/> Male <input type="checkbox"/> Female		Home Phone #	
City		County		State		Zip		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
<input type="checkbox"/> Union <input type="checkbox"/> Salaried <input type="checkbox"/> Non-union <input type="checkbox"/> Hourly		How many hours do you work per week?						E-mail address	

## B. PRODUCT SELECTION (Check all that apply)

<b>MEDICAL BENEFITS:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family Coverage <input type="checkbox"/> No Employee Coverage* <input type="checkbox"/> No Dependent Coverage*	<b>WAIVER OF COVERAGE SECTION (Must be completed if employee and/or dependents waive health coverage.)</b> <b>Note: If you are declining coverage for yourself or your dependents, because of other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.</b> <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my spouse <input type="checkbox"/> I decline coverage for my child(ren) - Child Name _____, Child Name _____, Child Name _____ The reason I am not applying for the coverage is: <input type="checkbox"/> Covered under spouse's group plan <input type="checkbox"/> Covered under another group plan - Copy of current carrier's ID card must be attached. Insurance Company Name, Address & Phone No. _____ Policy Number _____ Policyholder's Name _____ Policyholder's SS # _____ <input type="checkbox"/> Relationship to employee _____ <input type="checkbox"/> Other (please explain) _____
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\*Must be checked if coverage is waived.

## D. FAMILY INFORMATION

Employee and dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Employee/Dependent Social Security No.	Last Name	First Name	M.I.	Birthdate	Relationship**	Student	Sex	Resides w/ employee	Coverage
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change							<input type="checkbox"/> Yes <input type="checkbox"/> No School Name	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change							<input type="checkbox"/> Yes <input type="checkbox"/> No School Name	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change							<input type="checkbox"/> Yes <input type="checkbox"/> No School Name	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change							<input type="checkbox"/> Yes <input type="checkbox"/> No School Name	M F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

\*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Principal/Personal Physician (Primary Care) for yourself and each of your covered dependents for UnitedHealthcare Select, Select Plus.  
 \*Dependents are eligible for coverage if they are the age of 25 or under, dependent upon you for support, AND are living in your household OR are a full-time or part-time student.

## E. OTHER MEDICAL COVERAGE INFORMATION

Do you or your dependents have any other medical coverage?    YES    NO      If yes fill out this section >

Coverage type:    Group Policy    Individual Policy    Medicare/Medicaid

Insurance Company Name, Address and Phone Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Coverage Date to _____	Name of Policyholder _____	Policyholder's Birthdate / / _____	Family Members Covered by Medical Insurance
Name 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 (ESRD) <input type="checkbox"/> Disability <input type="checkbox"/> Retired

## F. WAIVER OF INSURANCE SIGNATURE (Form must be signed)

I understand that if I and/or my dependents, if any, waive health 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 dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X Employee Waiver Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

## H. IMPORTANT INFORMATION-PLEASE READ CAREFULLY

The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my and/or my dependents' coverage. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I understand that coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. Statements made to this application are representations not warranties. By signing this enrollment form, I hereby certify that all the information provided is true and correct.

## I. 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, I authorize any health care professional or entity to give the health plan/insurer 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 the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as the original. I understand that this health plan may contain a provision which excludes coverage for pre-existing conditions.

X  
 Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_