United Healthcare
A United Health Group Company

Enrollment Application/Change/Cancellation Request

Date:

Employee Information

☐ Enroll ☐ Address Change
☐ Cancel ☐ Name Change
☐ Change

Employee Position:

Last Name	First Name	MI	Social Security Number

Address	Apt#	City	State	Zip Code

Marital Status	Date of Birth	Work Phone
☐ Single ☐ Married	Sex: Male ☐	HonePhone
☐ Divorced ☐ Widowed	Female ☐	Cell Phone

Family Information

	Last Name	First Name	Social Security Number		
☐ Enroll ☐ Cancel ☐ Change	Birthday:	Relationship: **Spouse**		Sex: M ☐	F ☐
☐ Enroll ☐ Cancel ☐ Change	Birthday:	Relationship: **Dependent**		Sex: M ☐	F ☐
☐ Enroll ☐ Cancel ☐ Change	Birthday:	Relationship: **Dependent**		Sex: M ☐	F ☐
☐ Enroll ☐ Cancel ☐ Change	Birthday:	Relationship: **Dependent**		Sex: M ☐	F ☐
☐ Enroll ☐ Cancel ☐ Change	Birthday:	Relationship: **Dependent**		Sex: M ☐	F ☐

Waiver of Coverage

I decline coverage for:

☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:

☐ Spouse's Employer's Plan
☐ Medicare ☐ Medicaid
☐ VA Eligibility ☐ COBRA
☐ Individual Plan ☐ 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 experience a life change event, at the next enrollment period or a late enrollee, if applicable. I acknowledge that I have received the "Important Information" statement.

Employee Initials ☐

Signature

I confirm that the information I have provided on this form is complete and accurate. I understand that the health benefits 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 tobring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may conbine that information with other information so that it is no longer individually identifiable and use it for commerical and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date: Employee Signature: _____