

- NEW COVERAGE
 REQUEST FOR CHANGE

Enrollment Application and Change Form



PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY.

1 EMPLOYEE INFORMATION							
LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	
HOME ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE NUMBER ()		
EMPLOYER NAME Washington University		DIVISION/LOCATION	<input type="checkbox"/> UNION <input type="checkbox"/> NONUNION	<input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY	<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED Date _____	WORK PHONE NUMBER ()	

2 TYPE OF COVERAGE	3 WHO SHOULD BE COVERED	4 TYPE OF CHANGE
<input type="checkbox"/> Choice <input type="checkbox"/> Choice Plus <input type="checkbox"/> No Coverage (see Section 7) <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents Reason: <input type="checkbox"/> Covered under another plan. <input type="checkbox"/> Other: _____ (See Sec 6&7)	<input type="checkbox"/> Employee Only (00) <input type="checkbox"/> Employee Plus Child(ren) (02) <input type="checkbox"/> Employee Plus Spouse (03) <input type="checkbox"/> Employee Plus Child(ren) and Spouse (09)	<input type="checkbox"/> Add Spouse/Child (complete Sec 5) <input type="checkbox"/> Terminate Spouse/Child (complete Sec 5) <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec 5) <input type="checkbox"/> Terminate All Coverage - Reason _____
<i>* Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered late enrollees if you enroll in this plan at a later date.</i>		<input type="checkbox"/> Reinstatement - Reason _____ <input type="checkbox"/> Surviving Spouse Former Employee SSN _____ <input type="checkbox"/> COBRA Continuee Former Employee SSN _____ <input type="checkbox"/> Other _____

5 COVERAGE INFORMATION								
(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Zip Code	Date of Birth (Mo./Day/Yr.)	Sex	Handicapped?	Full-Time Student Over 19?
	Employee							
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F		
	Child-1					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child-2					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child-3					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 OTHER INSURANCE		
On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, Medicare or Medicaid? <input type="checkbox"/> Y <input type="checkbox"/> N		
Is another person legally responsible for coverage for your children? <input type="checkbox"/> Y <input type="checkbox"/> N		
If you answered yes to either of the questions above, please complete the following: <input type="checkbox"/> Y <input type="checkbox"/> N		
Person's Name with Other Health Plan		Social Security Number
Date of Birth	Sex	Other Company's Name and Phone Number
Other Company's Policy Number and Effective Date		
Medicare Number	Part A Effective Date	Part B Effective Date

7 AUTHORIZATION
<p>On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give The United HealthCare Insurance Company and its affiliates (and the employer) or any of their designees ("United HealthCare"), 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 on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependent's coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.</p> <p>If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.</p> <p style="text-align: center;">NOTICE OF ENROLLMENT RIGHTS</p> <p>I understand that if I and/or my dependents, if any, waive 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 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. Health insurance or medical services benefits provided or administered by The United HealthCare Insurance Company, Hartford, CT.</p>
<p>X Signature _____ Date _____</p>

8 TO BE COMPLETED BY EMPLOYER							
DATE OF HIRE	DATE SUBMITTED	HEALTH/CHANGE EFF. DATE	POLICY NUMBER 702111	PLAN VARIATION	REPORTING CODE	EMPLOYER SIGNATURE	

Enrollment Application and Change Form

Instructions

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 Complete all information.

SECTION 2 Check the coverage plan you would like (Be sure to check with your employer to see which plans are being offered).

SECTION 3 Select who should be covered on the plans.

SECTION 4 Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5 Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan.

T = To terminate yourself or a dependent's coverage.

C = To change information about yourself or a dependent.

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked COB (Coordination of Benefits) and complete Section 7. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is handicapped or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6 This section must be completed for all new enrollments or coverage changes.

SECTION 7 The employee must sign and date this form in order for it to be processed.

SECTION 8 This section is to be completed by the employer's benefit representative.