

California Small Business Employee Enrollment Form



UnitedHealthcare Insurance Company UnitedHealthcare of California UnitedHealthcare Benefits Plan of California

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

To Be Completed by Employer Group Name/Number Reason for Application Employee Type (check all that apply) Requested Effective Date of Insurance/Health Plan Coverage/Date of Change 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 Address Apt # City State ZIP Code Cell Phone Work Phone Date of Birth Sex Marital Status Have you or your dependents ever been a UnitedHealthcare member? Preferred Language Race/Ethnicity E-mail address Primary Care Physician Name Primary Care Dentist Name

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, Select Plus, Core, Doctors Plan, Non-Diff) Medical UnitedHealthcare of California (HMO) Dental UnitedHealthcare Benefits Plan of California or UnitedHealthcare Insurance Company or Dental Benefit Providers of California, Inc. Vision UnitedHealthcare Benefits Plan of California or UnitedHealthcare Insurance Company Administrative services provided by United Healthcare Services, Inc. Optum Rx Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

IMPORTANT: (1) 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. (2) 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. (3) 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. (4) For court-ordered dependent, legal documentation must be attached. (5) 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.

B. Dependent Information	List All Enrolling (attach sheet if necessary)		
Name (Last, First, M)	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Relationship <sup>4</sup> Spouse/ Domestic Partner	Date of Birth ____/____/____
Social Security Number         -     -			
Address (if different from Employee)	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____		
Race/Ethnicity – Check all that apply <sup>1</sup> <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____			ZIP Code
Primary Care Physician <sup>2</sup> Name: _____ Address: _____ ID# _____ Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist <sup>3</sup> Name: _____ ID#: _____ Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name (Last, First, M)	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Relationship <sup>4</sup> Dependent	Date of Birth ____/____/____
Social Security Number         -     -	Permanently Disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address (if different from Employee)	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____		
Race/Ethnicity – Check all that apply <sup>1</sup> <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____			ZIP Code
Primary Care Physician <sup>2</sup> Name: _____ Address: _____ ID# _____ Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist <sup>3</sup> Name: _____ ID#: _____ Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name (Last, First, M)	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Relationship <sup>4</sup> Dependent	Date of Birth ____/____/____
Social Security Number         -     -	Permanently Disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address (if different from Employee)	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____		
Race/Ethnicity – Check all that apply <sup>1</sup> <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____			ZIP Code
Primary Care Physician <sup>2</sup> Name: _____ Address: _____ ID# _____ Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist <sup>3</sup> Name: _____ ID#: _____ Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name (Last, First, M)	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Relationship <sup>4</sup> Dependent	Date of Birth ____/____/____
Social Security Number         -     -	Permanently Disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address (if different from Employee)	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____		
Race/Ethnicity – Check all that apply <sup>1</sup> <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____			ZIP Code
Primary Care Physician <sup>2</sup> Name: _____ Address: _____ ID# _____ Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist <sup>3</sup> Name: _____ ID#: _____ Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Plan Code/Description: _____
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Plan Code/Description: _____
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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?					
<input type="checkbox"/> Yes (continue completing this section) <input type="checkbox"/> 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) <sup>†</sup>	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:		/ /	/ /		
<sup>†</sup> 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.					
<b>If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):</b>					
Medicare – Employee/Spouse/Domestic Partner/Dependent Name: _____					
Medicare ID# _____ (Please attach a copy of your Medicare ID card.)					
<input type="checkbox"/> Enrolled in Part A: Effective Date ___/___/___		<input type="checkbox"/> Ineligible for Part A*		<input type="checkbox"/> Not Enrolled in Part A (chose not to enroll)	
<input type="checkbox"/> Enrolled in Part B: Effective Date ___/___/___		<input type="checkbox"/> Ineligible for Part B*		<input type="checkbox"/> Not Enrolled in Part B (chose not to enroll)	
<input type="checkbox"/> Enrolled in Part D: Effective Date ___/___/___		<input type="checkbox"/> Ineligible for Part D*		<input type="checkbox"/> Not Enrolled in Part D (chose not to enroll)	
<input type="checkbox"/> Disabled <input type="checkbox"/> Disabled but actively at work					
Reason for Medicare eligibility: <input type="checkbox"/> Over 65 <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Disabled <input type="checkbox"/> Disabled but actively at work					
Are you receiving Social Security Disability Insurance (SSDI)? <input type="checkbox"/> Yes <input type="checkbox"/> 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:				Declining coverage reason:
	Medical	Dental	Vision	<input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> COBRA/ Cal-COBRA
Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> California Health Benefit Exchange    AB1401 from Prior Employer
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Tri-Care
Dependent Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> VA Eligibility <input type="checkbox"/> I (we) have no other coverage at this time
Myself and all dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____

**E. Waiver of Coverage (continued)**

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

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 ____/____/____
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**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.

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.

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