CHOICE & CHOICE Plus products offered by
United HealthCare Insurance Company of New York

GROUP ENROLLMENT/CHANGE CANCELLATION FORM

UNITEDhealthcare®

A. ACTION (COMPLETE APPLICABLE BOX BELOW)

☐ **New Enrollment/Additions: (check one)**
- ☐ New Hire
- ☐ Open Enrollment
- ☐ Status Change (PT to FT) on ____/____/____
- ☐ Return from Leave/Layoff on ____/____/____
- ☐ Birth on ____/____/____
- ☐ Marriage on ____/____/____
- ☐ Adoption (attach legal document)
- ☐ Other (describe) _____

Requested Effective Date of Enrollment _____

☐ **Cancellations:**
- ☐ Cancel all coverage
- ☐ Cancel dependents listed below in Section D

Reason: (check one)
- ☐ Death ☐ Employee Termination
- ☐ Divorce ☐ Moved out of service area
- ☐ Dependent reached student/dependent max age
- ☐ Other (describe) _____

If COBRA participant, start date _____ stop date _____
Requested Effective Date of Cancellation _____

☐ **Change:**
- ☐ Street Address To: _____
- ☐ Home Phone To: _____
- ☐ Name To: _____
- ☐ Electing Continuation Coverage
- ☐ Change in Other Health Insurance Information (complete E)
- ☐ Other (describe) _____

Requested Effective Date of Change _____

B. EMPLOYEE INFORMATION

First Name | M.I. | Last Name | Social Security Number

Street Address | City | State | Zip Code | Home Phone ( ) | Work Phone ( )

Sex ☐ M ☐ F | Date of Birth | Marital Status ☐ Married ☐ Single | Date of Hire | ☐ Full Time ☐ Part Time

C. COVERAGE SELECTION

I which to enroll:

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children ☐ None. Waive Coverage.

D. FAMILY INFORMATION

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

Check appropriate box	Employee/Dependent Social Sec. No.	Last Name	First Name	M.I.	Birthdate	Relationship	Sex (M or F)	Full-Time College Student
☐ Enroll ☐ Cancel ☐ Change						SPOUSE		
☐ Enroll ☐ Cancel ☐ Change								☐ YES ☐ NO School Name:
☐ Enroll ☐ Cancel ☐ Change								☐ YES ☐ NO School Name:
☐ Enroll ☐ Cancel ☐ Change								☐ YES ☐ NO School Name:

*If your dependent does not reside with you, or is 19 years or older and a full-time student in an accredited educational institution, please list the school they are attending above and their present address on a separate sheet of paper. Coverage will not be offered to dependents living outside of the service area, unless they are a full-time student as defined above or coverage is required by a court degree. If you are subject to a court decree to provide health coverage for any of the dependents listed above, please provide a copy of the decree.

E. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins will any family members, including those not listed above, be covered by other health or dental insurance or Medicare?

☐ YES ☐ NO If yes, fill out this section. Use extra paper if more than one additional policy will be in force.

Coverage Type	Insurance Company Name and (Area Code) Phone Number	Policy Number
☐ Medical Insurance ☐ Dental Insurance ☐ Medicare (see below)		

Policy Coverage Dates	Name of Insured	Insured's Date of Birth	Insured's Employer Name

Names of family members covered by Medicare

F. SIGNATURE (FORM MUST BE SIGNED)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone, enrolled on or added to this application ("US"), I authorize any health care professional or entity to give United HealthCare Insurance Company of New York and the employer or any of their designees, any and all records or information as permitted by law 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. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.

X _____ Date Signed

Employee Signature

G. EMPLOYER AUTHORIZATION

Company Name	Date of Employment	Group Policy Number	Position	Date

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This enrollment form acts as a temporary I.D. Card. If you should have any questions please contact the Member Services Department.

The temporary I.D. status is only good for 31 days after the Employee's Signature Date.

a. I understand that I am responsible for reporting to my employer promptly any changes in my marital status, in the number of my eligible dependents, or any change in my residence.

b. I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by United HealthCare Insurance Company of New York or any affiliated insurance carrier with respect to any claim or the delivery of medial care on account of myself or a covered dependent I understand and agree that this information may be released by United HealthCare Insurance Company of New York or any affiliated insurance organization to other persons and entities as necessary to administer coverage, perform managed care activities, comply with legal requirements and do statistical analysis.

c. I agree that any hospital benefits payable on my account under my employer's Group Medical Benefits Plan may be paid directly to the provider of care.

d. I understand and agree that no benefits shall take effect until this enrollment form is approved by United HealthCare Insurance Company of New York. Upon acceptance, United HealthCare Insurance Company of New York shall as soon as possible, issue an identification card(s) to the Member to evidence coverage hereunder.

e. I authorize my employer to make the necessary deductions from my pay or from any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer while I am enrolled in United HealthCare Insurance Company of New York, or until this authorization is revoked by me in writing.

f. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

g. I understand that if I enroll outside the open enrollment period as a late enrollee, my coverage may be deferred until the next open enrollment period.

*If you have eligible Dependents, but do not select Dependent coverage, your Dependents will not be entitled to any benefits under the Plan. Not selecting personal coverage means you also will not be entitled to any benefits under the plans.