UNITEDhealthcare® of New York, Inc.

SMALL GROUP SELECT HMO ENROLLMENT FORM

Please print clearly and be sure to sign and date this form. Return completed form to your employer's personnel office. Make a copy for your records.

1. EMPLOYEE INFORMATION

Employee Name (Last) (First) (Middle)	Social Security Number	Marital Status ☐ Single ☐ Married

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

2. OTHER INSURANCE

Do you or any of your dependents have coverage under any other medical plan? ☐ Yes ☐ No If yes, provide the following information below.

Name of Spouse/Dependent	Employer Name/Phone	Individual or Family Membership	Insurance Company Name	Are you or any of your dependents eligible for Medicare? ☐ Yes ☐ No

Were you covered by another medical/hospital plan, other than United HealthCare, within the last 12 months? ☐ Yes ☐ No If yes, please provide the information below.

Name of Plan	Address	Identification Number	Date of Termination

3. TYPE OF COVERAGE

Individuals to be covered *(Please see reverse side.)* ☐ Employee Only (Single) ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee, Spouse and Child(ren)

If you are declining coverage for your self 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 a late enrollee if you enroll in this plan at a later date.

☐ I do not wish Medical or other coverages for myself or my dependents. If this box is checked, please stop here and sign and date the bottom of form.

4. EMPLOYEE AND DEPENDENT INFORMATION

Family members to be enrolled (If more space is needed, please use an additional enrollment form.)

Last Name / First Name / Middle Initial	Date of Birth MM/DD/YY	Sex	Handicapped?	Full-time Student Over 19?	Name of Primary Care Physician*	Current Patient?	United HealthCare ID Number
Employee		☐M ☐F				☐Y ☐N	
Spouse		☐M ☐F	☐Y ☐N			☐Y ☐N	
Dependent Child		☐M ☐F	☐Y ☐N	☐Y ☐N		☐Y ☐N	
Dependent Child		☐M ☐F	☐Y ☐N	☐Y ☐N		☐Y ☐N	
Dependent Child		☐M ☐F	☐Y ☐N	☐Y ☐N		☐Y ☐N	

* **IMPORTANT:** Please use the United HealthCare directory of providers to choose a Primary Care Physician (PCP), for yourself and each of your covered dependents.

5. AUTHORIZATION

I certify that all information supplied on this form is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan contract. I agree to abide by the terms and conditions governing membership and receipt of health services covered by the plan in which I have enrolled, and agree to provisions as stated on reverse side of this form.

Notice of Enrollment Rights

I understand that if I and/or my dependents, if any, waive any 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 other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement 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.

Signature of the Employee: _____ Date Signed: _____

6. TO BE COMPLETED BY EMPLOYER

Employer (Group) Name	Group Number/Policy Number	Date of Hire	United HealthCare Location (City & State)

Refer to Terms and Conditions on reverse side

UNITEDhealthcare®

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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 or any affiliated insurance carrier with respect to any claim or the delivery of medical care on account of myself or a covered dependent.

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. Upon such acceptance, United HealthCare 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 the United HealthCare program, or until this authorization is revoked by me in writing.

f. United HealthCare will arrange to provide covered services in connection with a Pre-Existing Condition after a Member has been covered under United HealthCare for a continuous period of 12 months. However, United HealthCare will credit continuous time covered under a prior health plan if that coverage ended not more than 62 days prior to the member's effective date of coverage under United HealthCare.

"Pre-Existing Condition" means a condition where medical advice, diagnosis, care or treatment was recommended or received within a 6 month period ending on member's enrollment date under United HealthCare.

g. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The following rules are applicable where allowed by law. Note: certain eligibility rules are prohibited by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA applies to participants of new groups written on and after July 1, 1997 and to participants of existing groups on the group's first plan year on or after July 1, 1997.

* 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 plan.

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