UNITEDhealthcare® of New York, Inc.

SELECT PLUS HMO+
SMALL EMPLOYER 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

3. TYPE OF COVERAGE

Individuals to be covered
(Please see reverse side.)

A. ☐ Employee Only (Single) ☐ Employee and Spouse ☐ I do not wish Medical and other contributory coverage for myself or my dependents.
☐ Employee and Child(ren) ☐ Employee, Spouse and Child(ren) If this box is checked, please stop here and sign and date the bottom of this form.

B. Medical Coverage Type: ☐ I am enrolling in the United HealthCare Select Plus, and the United HealthCare Insurance Company of New York.

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 and in some service areas the hospital with which the PCP is affiliated, 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 the reverse side of this form.

Signature of the Employee _____ Date _____

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

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Enrollment Form

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 of New York or United HealthCare Insurance Company 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 of New York or United HealthCare Insurance Company. Upon such acceptance, a United HealthCare Select Plus identificaiotn card(s) shall be issued 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 Select Plus program, or until this authorization is revoked by me in writing.

f. The following applies if you are enrolling through a small employer (3-50 lives):

I acknowledge that, according to New York State regulations governing small group health insurance, if I am presently without coverage for more than 60 days, then a pre-existing condition waiting period will apply to any new coverage. Pre-existing waiting periods apply to persons with conditions diagnosed or recommended for treatment within six months prior to the effective date of new coverage and shall not exceed 12 months following this date.

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.

* 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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United HealthCare Insurance Company of New York, Inc.