

United Healthcare Enrollment/Change Form

A. Employee Information

First Name M.I. Last Name Social Security #

Street Address City County State Zip Country

Home Phone: _____ Date of Hire: _____

Marital Status: Single Married Divorced Widowed

Gender: M F

Date of Birth: ___/___/_____ (MM/DD/YYYY)

B. Desired Action

Enroll Cancel Change

Enrollment Product Selection:

Plan: \$500 Deductible POS Plan \$1,000 Deductible POS Plan

\$1,500 Deductible and HSA-Eligible POS Plan

Tier: Employee Only Employee + 1 Dependent Employee + Family

Cancellation Desired:

Cancel Medical Coverage, Reason: _____

Date of Qualifying Event: ___/___/_____ (MM/DD/YYYY)

Remove Dependent(s), Reason: _____

Date of Qualifying Event: ___/___/_____ (MM/DD/YYYY)

Change Desired:

Plan Change (new plan selection should be indicated in *Enrollment Product Selection* above)

Requested Change: _____

Name Change, Reason: _____

New Name: _____

Date of Qualifying Event: ___/___/_____ (MM/DD/YYYY)

Address Change (*new address should be listed in Section A*)

Add Dependents, Reason: _____

Date of Qualifying Event: ___/___/_____ (MM/DD/YYYY)

All mid-year changes require documentation of marriage, divorce, adoption, termination of other coverage, etc. Change paperwork must be received by HR within 30 days of the date of a Qualifying Event. Changes received outside of this period must be denied under the Section 125 tax law.

C. Family Members

Please use the first box on each line to indicate the type of change being made: A=Add a Member, R=Remove a Member

Type of Change	Name (First, MI, Last)	Relation	Dependent's Social Security #	Gender	Date of Birth (MM/DD/YYYY)	Age	Disabled? (Y/N)

D. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

Date: _____ Signature: _____