

**ENROLLMENT / CHANGE / CANCELLATION FORM**

**UnitedHealthcare of Ohio, Inc.**

For Plan Use Only:

**A. EMPLOYER AUTHORIZATION (FOR EMPLOYER USE ONLY)**

Group Number \_\_\_\_\_ Company Name \_\_\_\_\_ Dept. No. \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_ Approved By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**B. ACTION (COMPLETE APPLICABLE BOX BELOW)**

<p><b>New Enrollment/Additions (check one)</b></p> <p><input type="checkbox"/> New Hire - Date of Hire: ____/____/____</p> <p><input type="checkbox"/> Open Enrollment</p> <p><input type="checkbox"/> Status Change (PT to FT) on ____/____/____</p> <p><input type="checkbox"/> Return from Leave/Layoff on ____/____/____</p> <p><input type="checkbox"/> Birth (enter child's name and date of birth in Section D)</p> <p><input type="checkbox"/> Marriage on ____/____/____</p> <p><input type="checkbox"/> Adoption (attach legal documentation)</p> <p><input type="checkbox"/> Other (describe) _____</p>	<p><b>Cancellations (check all that apply)</b></p> <p><input type="checkbox"/> Cancel all coverage</p> <p><input type="checkbox"/> Cancel only: <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Cancel dependents listed below - Section D</p> <p>Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of Service Area</p> <p><input type="checkbox"/> Employee Terminated <input type="checkbox"/> Dependent reached student/depend. maximum age</p> <p><input type="checkbox"/> Other (describe) _____</p>	<p><b>Change: (check all that apply)</b></p> <p><input type="checkbox"/> Transfer from Group No. _____ to Group No. _____</p> <p><input type="checkbox"/> Change Address (enter new address in Section C)</p> <p><input type="checkbox"/> Change Name (enter new name in Section C or D)</p> <p><input type="checkbox"/> Electing Continuation Coverage</p> <p><input type="checkbox"/> Change in Other Health Insurance Information (complete Section E)</p> <p><input type="checkbox"/> Change Product or Selection</p> <p><input type="checkbox"/> Change Beneficiary (complete Section F)</p> <p><input type="checkbox"/> Other (describe) _____</p>
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**C. EMPLOYEE INFORMATION**

Employee Social Security Number \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Marital Status:  Single  Married Employer's Company Name/Division \_\_\_\_\_ Employee Status:  Full Time  Salaried  Bargaining  Part Time  Hourly  Non-Bargaining  Retired  Exec.

Home Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**E. OTHER HEALTH INSURANCE - Failure to complete this section may result in claims being disallowed until information is provided.**

**D. FAMILY INFORMATION Employee, Spouse, Dependents to be enrolled, cancelled, changed: (attach extra sheet, if needed.)**

Coverage will not be offered to a dependent living outside the service area, unless he/she is a full-time student or coverage is required by court decree. If you are required by court decree to provide coverage for any dependent listed below, please attach a copy of the decree.

On the day your coverage begins will any family members be covered by other health insurance, including another UnitedHealthcare policy, or Medicare? If yes, complete questions below. (Attach additional sheet, if needed)

Check Appropriate Box	Relationship	First Name	M.I.	Last Name	Sex	Date of Birth (MM/DD/YY)	Social Security Number	Resides with Employee	Other Medical Insurance	Insurance Company Name (if Medicare, Complete below)	Policyholder Name & Policy Number	Policyholder's Employer Name	Policy Coverage Dates
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	EMPLOYEE				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SPOUSE				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change					<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change					<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change					<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				From: To:

Complete the following for any family member covered by Medicare:

Name of family member	Medicare Claim Number	Part A Effective Date	Part B Effective Date	Is Medicare eligibility due to: <input type="checkbox"/> Kidney failure <input type="checkbox"/> Disability

**F. PRODUCT SELECTION (CHECK ALL THAT APPLY)**

Non-Network benefits provided by UnitedHealthCare Insurance Company of Ohio.  
Non-Medical products provided by UnitedHealthCare Insurance Company.

<p><b>MEDICAL BENEFITS:</b></p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee + 1 or more Dependents</p> <p><input type="checkbox"/> No Medical Coverage*</p>	<p><b>DENTAL BENEFITS:</b></p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee + 1 or more Dependents</p> <p><input type="checkbox"/> No Dental Coverage*</p>	<p><b>OTHER NON-MEDICAL BENEFITS:</b></p> <p><input type="checkbox"/> Employee Life/Accidental Death &amp; Dismemberment</p> <p><input type="checkbox"/> Dependent Life</p> <p><input type="checkbox"/> Supplemental Life</p>	<p><b>BENEFIT LEVEL (EMPLOYER USE ONLY)</b></p> <p>Salary Per \$ _____</p> <p><input type="checkbox"/> Week <input type="checkbox"/> Year</p> <p><input type="checkbox"/> Month</p>	<p>Your Beneficiary's Full Name _____</p> <p>Relationship: _____</p> <p>Contingent Beneficiary (If applicable) _____</p> <p>Relationship: _____</p>
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**G. SIGNATURE (FORM MUST BE SIGNED FOR ANY ENROLLMENT, CHANGE OR CANCELLATION ACTIVITY)**

**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 UnitedHealthcare of Ohio, Inc. or any of their designees any and all records or information 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. **FRAUD WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

**UnitedHealthcare** A UnitedHealth Group Company

x \_\_\_\_\_ / \_\_\_\_/\_\_\_\_ x \_\_\_\_\_ / \_\_\_\_/\_\_\_\_

Employee Signature Date Signed Spouse Signature Date Signed

OH 50A (10/00)

**For Employer Use Only: \***

**Submit completed applications to UnitedHealthcare at the mailing address of Fax number listed below.**

Mailing Address (for all groups located in Ohio)

**Ohio Enrollment  
MN002-0240  
P.O. Box 1459  
Minneapolis, MN 55440-1459**

Or Fax to the number below:

**(952) 833-6105**

Employees: *Please do not mail or Fax this form directly to UnitedHealthcare.* Give the completed form to your employer or group administrator who will submit to UnitedHealthcare.