

Enrollment Application/Change/Cancellation Request



You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

UnitedHealthcare Insurance Company
 UnitedHealthcare of Texas, Inc.
 UnitedHealthcare Benefits of Texas, Inc.
 National Pacific Dental, Inc.

- | | |
|---------------------------------|---|
| <input type="checkbox"/> Enroll | <input type="checkbox"/> Address Change |
| <input type="checkbox"/> Cancel | <input type="checkbox"/> Name Change |
| <input type="checkbox"/> Change | Date of Change ___/___/___ |

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name _____	Group # _____	Department # _____
--------------------	---------------	--------------------

Plan Variation Medical _____ Vision _____ Dental _____ Life _____	Reporting Code Medical _____ Vision _____ Dental _____ Life _____	Benefit Level/Class Code, if applicable Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____
--	--	--

<input type="checkbox"/> New Enrollment/Additions: (Check one) Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Court ordered dependent <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/State Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___/___/___	<input type="checkbox"/> Cancellations: Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel all listed below – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached dependent max age <input type="checkbox"/> Other (describe) _____
--	---

Employee Type <input type="checkbox"/> Union <input type="checkbox"/> Non-union	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	<input type="checkbox"/> Active <input type="checkbox"/> COBRA/State Cont. <input type="checkbox"/> Retire Date _____	#Hours worked per week _____
--	---	---	------------------------------

Signature _____ Date _____

A. Employee Information

Employer Position _____ Phone Number _____

Last Name _____	First Name _____	MI _____	Social Security Number _____
-----------------	------------------	----------	------------------------------

Address _____	Apt # _____	City _____	State _____	Zip Code _____	Home/Cell Phone _____
---------------	-------------	------------	-------------	----------------	-----------------------

Date of Birth ___/___/___	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Work Phone _____
---------------------------	--	---	------------------

Email Address _____	Race – Check all that apply (Optional) ² <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____
Language Preference, if not English _____	

Primary Physician, Obstetrician or Gynecologist ¹ Physician First & Last Name _____ ID # _____	Primary Dentist ¹ Dentist First & Last Name _____ ID# _____
---	--

Do you have a disability affecting your ability to communicate or read? Yes No

¹IMPORTANT: Please see employer representative as some UnitedHealthcare Health Maintenance Organization (HMO) products require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection. HMO female enrollees are not required to select an obstetrician or gynecologist. Obstetrical or gynecological care can be received from her primary care physician, primary care provider or an obstetrician or gynecologist. ²Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

B. Family Information

List All Enrolling/Changing/Canceling (Attach sheet if necessary)

Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Relationship ² Spouse /Domestic Partner	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____
	Social Security Number			Primary Physician, Obstetrician or Gynecologist ¹ Name: _____ ID# _____ - _____		
Race – Check all that apply (Optional) ³ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify _____						Primary Care Dentist ¹ Name: _____ ID# _____
Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Relationship ² Dependent	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____
	Social Security Number			Primary Physician, Obstetrician or Gynecologist ¹ Name: _____ ID# _____ - _____		
Race – Check all that apply (Optional) ³ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify _____						Primary Care Dentist ¹ Name: _____ ID# _____
Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Relationship ² Dependent	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____
	Social Security Number			Primary Physician, Obstetrician or Gynecologist ¹ Name: _____ ID# _____ - _____		
Race – Check all that apply (Optional) ³ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify _____						Primary Care Dentist ¹ Name: _____ ID# _____
Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Relationship ² Dependent	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____
	Social Security Number			Primary Physician, Obstetrician or Gynecologist ¹ Name: _____ ID# _____ - _____		
Race – Check all that apply (Optional) ³ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify _____						Primary Care Dentist ¹ Name: _____ ID# _____

¹IMPORTANT: Please see employer representative as some UnitedHealthcare Health Maintenance Organization (HMO) products require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection. HMO female enrollees are not required to select an obstetrician or gynecologist. Obstetrical or gynecological care can be received from her primary care physician, primary care provider or an obstetrician or gynecologist.

²For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

³Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.

Person	PPO	HMO	HSA		
Employee Only	_____	_____	_____		
Employee + Spouse	_____	_____	_____		
Employee + Child	_____	_____	_____		
Employee + Family	_____	_____	_____		

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
 S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
 F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.
 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

Medicare – Spouse/Dependent Name: _____
 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
 Myself
 Spouse
 Dependent Children
 Myself and all dependents

Declining coverage due to existence of other coverage:
 Spouse's Employer's Plan Individual Plan
 Covered by Medicare Medicaid
 COBRA from Prior Employer VA Eligibility
 Tri-Care
 I (we) have no other coverage at this time
 Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date
-------------------	------

F. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

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. 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.

I acknowledge that I have received the "Important Information" statement which is included at the end of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)
------	---	---

Texas Mandatory Disclosure Statement:

Dental indemnity benefits are provided through UnitedHealthcare Insurance Company and Dental HMO (DHMO) benefits are offered through National Pacific Dental, Inc. In order to receive benefits from the DHMO plan, an enrollee must utilize only network providers, except for emergency dental care, and pay the copayments specified in the evidence of coverage. To receive benefits under the dental indemnity plan, the enrollee may utilize any provider but prior to receiving reimbursement, the enrollee must meet the required deductible and is responsible for the coinsurance amount specified in the policy or certificate.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company (PPO, indemnity), UnitedHealthcare of Texas, Inc. (HMO) or UnitedHealthcare Benefits of Texas, Inc. (HMO)
Dental coverage provided by UnitedHealthcare Insurance Company (indemnity), National Pacific Dental, Inc. (HMO)
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.