

Enrollment/Change Form

Group Dental Insurance, Vision Care Insurance, Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance and Voluntary AD&D provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
 185 Asylum St.
 Hartford, CT 06103-3408



TO BE COMPLETED BY EMPLOYER

Employer Name: <u>HealthGuys Inc.</u>	Policy Number: <u>00926643</u>
Employer Authorization:	Date of Hire: _____
Plan Variation/Reporting Code: _____	Class: _____
Requested Effective Date of Coverage / Date of Change: _____	Plan: _____
	<input type="checkbox"/> Enroll <input checked="" type="checkbox"/> Cancel <input type="checkbox"/> Change
Reason: (Check the Appropriate Boxes)	
<input type="checkbox"/> New Group Plan	<input type="checkbox"/> New Hire
<input type="checkbox"/> Name Change	<input type="checkbox"/> Employee Terminated
<input type="checkbox"/> Divorce	<input type="checkbox"/> Court Ordered Dependent
<input type="checkbox"/> Adoption/Legal Custody	<input type="checkbox"/> Annual Open Enrollment
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Marriage
	<input type="checkbox"/> Death
	<input type="checkbox"/> Cobra/State Continuation
	Start Date ___/___/___ End Date ___/___/___
	<input type="checkbox"/> Address Change <input type="checkbox"/> Birth

EMPLOYEE INFORMATION

SS# _____ - _____ - _____	Employer Assigned ID# _____	Date of Birth: ___/___/___
Last Name: _____	First Name: _____	Middle Initial: _____
Address: _____	City: _____	State: _____ Zip Code: _____
Home Phone: _____	Work Phone: _____	Email Address: _____ Annual Salary: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner *	
Number of hours worked per week: _____		
Employee Type (Check all that apply): <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Retired <input type="checkbox"/> Other		

FAMILY INFORMATION

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name	MI	Last Name (if different)	Date of Birth	Sex	Relationship**	Incapacitated***
	Dependent Social Security Number or Assigned ID						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner*	Not Applicable
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Domestic Partner coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation.

** For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, incapable of self-sustaining employment because of mental retardation or physical disability, and chiefly dependent on the subscriber/covered person for support and maintenance. If answered "Yes" for Incapacitated, please attach medical certification of disability.

BENEFIT ELECTIONS					
Person	Dental	Vision	STD	LTD	
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____ <input type="checkbox"/> Buy-up	<input type="checkbox"/> _____ <input type="checkbox"/> Buy-up	
Spouse (or Domestic Partner)	<input type="checkbox"/>	<input type="checkbox"/>			
Dependent	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input checked="" type="checkbox"/> Waive (if applicable)	<input checked="" type="checkbox"/> Waive (if applicable)	
Person	Basic Life	Basic AD&D	Supplemental Life	Supplemental AD&D	Voluntary AD&D
Employee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Spouse (or Domestic Partner)	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dependent	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
	<input checked="" type="checkbox"/> Waive (if applicable)	<input checked="" type="checkbox"/> Waive (if applicable)	<input checked="" type="checkbox"/> Waive Have you used tobacco of any kind in the past 12 months? Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Waive	<input checked="" type="checkbox"/> Waive (if applicable)

BENEFICIARY(IES) *		Beneficiary(ies) to be designated at time of Enrollment.					
Product	Full Name	%	Address Code	City	State	Zip	Relationship
Life & AD&D	Primary						
	Secondary/Contingent						

* Do not use to change a previously designated Beneficiary. For changes, use the Beneficiary Designation form available from the Employer.

AUTHORIZATION AND ACKNOWLEDGEMENT Form must be signed

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided on next page.

Employee/Enrollee Signature:	Date:
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