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

UnitedHealthcare®

TO BE COMPLETED BY EMPLOYER

Employer Name: Health Guys Inc.		Policy Number: 00926643
Employer Authorization: [signature]	Date of Hire: ____	Class:
	Plan Variation/Reporting Code:	Plan: P5424
Requested Effective Date of Coverage / Date of Change: 1/1/24		☑ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan	☐ New Hire	☑ Annual Open Enrollment	☐ Address Change
☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Birth
☐ Divorce	☐ Court Ordered Dependent	☐ Death	
☐ Adoption/Legal Custody		☐ Cobra/State Continuation	
☐ Other:		Start Date ___/___/___ End Date ___/___/___	

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: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Domestic Partner *

Number of hours worked per week:______________

Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

FAMILY INFORMATION

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

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/_____	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/_____	☐ M ☐ F	Dependent	☐Yes ☐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 Spouse (or Domestic Partner) Dependent	☐ ☐ ☐ ☐ Waive (if applicable)	☐ ☐ ☐ ☐ Waive (if applicable)	☐ ____ ☐ Buy-up ☑ Waive (if applicable)	☐ ____ ☐ Buy-up ☑ Waive (if applicable)

Person	Basic Life	Basic AD&D	Supplemental Life	Supplemental AD&D	Voluntary AD&D
Employee Spouse (or Domestic Partner) Dependent	☐ $_____ ☐ $_____ ☐ $_____ ☑ Waive (if applicable)	☐ $_____ ☑ Waive (if applicable)	☐ $_____ ☐ $_____ ☐ $_____ ☑ Waive Have you used tobacco of any kind in the past 12 months? Employee? ☐ Yes ☐ No Spouse? ☐ Yes ☐ No	☐ $_____ ☐ $_____ ☐ $_____ ☑ Waive	☐ $_____ ☐ $_____ ☐ $_____ ☑ 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: