

Enrollment Application and Change Form – ASO

PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY.



New Coverage Request for Change

1 EMPLOYEE INFORMATION						
Last Name	First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Home Address		City		State	Zip Code	Home Phone Number ()
Employer Name		Division/Location		<input type="checkbox"/> FT <input type="checkbox"/> Union <input type="checkbox"/> PT <input type="checkbox"/> Nonunion	<input type="checkbox"/> Hourly <input type="checkbox"/> Active <input type="checkbox"/> Salary <input type="checkbox"/> Retired (Date _____)	Work Phone Number ()

2 TYPE OF COVERAGE
<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents Reason: <input type="checkbox"/> covered under another plan <input type="checkbox"/> Other: _____

3 TYPE OF CHANGE
<input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec. 5) <input type="checkbox"/> Terminate All Coverage <input type="checkbox"/> Reinstatement <input type="checkbox"/> Surviving Spouse – Former Employee SSN <input type="checkbox"/> COBRA Continuee – Former Employee SSN

4 OTHER MEDICAL COVERAGE INFORMATION
<i>(This section must be completed. Attach additional sheet if necessary.)</i>

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

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 policy holder 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.

5 COVERAGE INFORMATION								
(A) Add (T) Term (C) Change	Last Name	First Name	MI	ZIP Code	Date of Birth (Mo/Day/Yr)	Sex	Handi-capped?	Full Time Student over 19?
	Employee							
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F		
	Child 1					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 2					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 3					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 AUTHORIZATION
<p>On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give the insurance company(ies) and their affiliates (and the employer) 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. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.</p> <p>If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.</p> <p style="text-align: center;">NOTICE OF ENROLLMENT RIGHTS</p> <p>I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.</p> <p>X Signature _____ Date _____</p>

Medicare - Employee Information: if enrolled in Medicare, please attach a copy of your Medicare ID card.

Part A Enrolled: Effective Date _____ Ineligible* Not Enrolled (chose not to enroll)
Part B Enrolled: Effective Date _____ Ineligible* Not Enrolled (chose not to enroll)
Part D Enrolled: Effective Date _____ Ineligible* Not Enrolled (chose not to enroll)

Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

Medicare - Spouse/Dependent Name: _____

Part A Enrolled: Effective Date _____ Ineligible* Not Enrolled (chose not to enroll)
Part B Enrolled: Effective Date _____ Ineligible* Not Enrolled (chose not to enroll)
Part D Enrolled: Effective Date _____ Ineligible* Not Enrolled (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*

7 TO BE COMPLETED BY EMPLOYER							
Date of Hire	Date Submitted	Enroll/Change Eff. Date	Policy Number	Medical Plan Var/Rpt Code	Dental Plan Var/Rpt Code	Vision Plan Var/Rpt Code	Employer Signature
				/	/	/	

Enrollment Application and Change Form

INSTRUCTIONS

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 Complete all information.

SECTION 2 Check the coverage plan you would like.

SECTION 3 Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 4 This section for all new enrollments or coverage changes.

SECTION 5 Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan

T = To terminate your or a dependent's coverage

C = To change information about yourself or a dependent

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, be sure to complete Section 4. **IMPORTANT** – be sure to include the Social Security Number, zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is handicapped or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6 The employee must sign and date this form in order for it to be processed.

SECTION 7 This section is to be completed by the employer's benefit representative.