Employee Enrollment Form for an Association Health Plan

Wisconsin

UnitedHealthcare®

Please fill out the entire enrollment form to avoid processing delay.
Please clearly print all information.

Association Health Plan Name:

Group/Policy #	Employer Name	Requested Effective Date of Coverage / Date of Change

Employer Address (if more than one location)

Employee Type (check all that apply):
☐ Active ☐ COBRA ☐ State Continuation
Start date ____/____/____
End date ____/____/____
☐ Hourly ☐ Salary ☐ Union
☐ Non-Union ☐ Retired
☐ Other _____

Reason for Application / Change Request (check all that apply):
☐ New Group Plan ☐ New Hire ☐ Annual Open Enrollment
☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption or Placement for Adoption
☐ Court Order ☐ Loss of other coverage (employee or dependent) ☐ Termination
☐ Returning to School Full Time ☐ Other_____
Date of Event: _____ (You may be required to provide proof of event.)

Enrollee Information

Enrollee Social Security Number	Last Name	First Name	Initial

Address	City	State	Zip Code

Date of Birth	Gender	Marital Status	Preferred Phone:
	☐ M ☐ F	☐ Single ☐ Married	☐ Home ☐ Cell ☐ Work ( ) –

Height	Weight	Email Address

Date of Hire	Hours Worked Per Week	Occupation	Are you an independent contractor?
			☐ Yes ☐ No

Enrollee and Dependent Information (Only for those applying.)

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ☐

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Middle Initial					
Last Name					
Gender		☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Date of Birth					
Social Security Number					
Height/Weight					
Primary Care Physician's Name	Existing Patient? ☐ Yes ☐ No	Existing Patient? ☐ Yes ☐ No	Existing Patient? ☐ Yes ☐ No	Existing Patient? ☐ Yes ☐ No	Existing Patient? ☐ Yes ☐ No
Primary Care Physician's ID number					

Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Wisconsin, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Enrollee Name: _____

Coverage Selection	Please check the box for each coverage you or your dependents are enrolling in. If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	**Medical**	**Dental**	**Vision**	**Basic Life/AD&D**	**Supp Life/AD&D**
Enrollee	☐ _____	☐ _____	☐ _____	☐ $_____	☐ $_____
Spouse/Domestic Partner	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	**STD**	**STD Buy Up**	**LTD**	**LTD Buy Up**	Salary $ _____ Required only if Life, STD, or LTD based on salary
Enrollee	☐ $_____	☐ $_____	☐ $_____	☐ $_____	

Life Insurance Beneficiary (if applying for Life Insurance with UnitedHealthcare)

	Full Name and Address	**Relationship**
Primary		
Secondary		

Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)

	Enrollee	**Spouse**	**Child 1**	**Child 2**	**Child 3**
Currently Working Full Time	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Plan to Keep Other Insurance Coverage	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare / Medicaid	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Medicare/Medicaid Coverage Effective Date					

Prior Medical Coverage Information

☐ Yes ☐ No Have you or any dependents applying for coverage previously had coverage under your employer's group health plan?

If Yes:

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date_____ Effective Date_____ Reason for Termination _____

Type of Plan: ☐ Prior Employer Group Plan ☐ Spouse's Employer Group Plan ☐ Individual Policy

☐ Other _____

Enrollee Name: _____

Signature

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 declare all statements contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 90 days that was provided to the Association Health Plan (AHP), are true and correct and that no material information has been withheld or omitted. I understand and agree that the AHP is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Plan Documents. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in rescission of the AHP coverage, termination of such coverage, an increase in the payment amount retroactive to the coverage date, or other consequences as permitted by law.

All pages must be attached and complete, including this authorization, for the enrollment form to be considered complete. Incomplete enrollment forms may be rejected.

Enrollee Signature _____ Date _____

Waiver (Please complete if you are waiving medical coverage.)

I waive medical coverage for:

- ☐ Myself
- ☐ Spouse
- ☐ Dependent Children
- ☐ Myself and all dependents

Please state reason for waiving coverage:

- ☐ Existence of other Qualifying Coverage _____
- ☐ Other reason _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Enrollee Signature _____ Date _____