(DO NOT STAPLE)

Employee Enrollment Form
New York

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed By Employer | **Requested Effective Date of Coverage/Date of Change** / /

Group Name	Policy number

Date Of Hire	Reason for Application	Employee Type (Check all that apply)
Position/Title	☐ New Group Plan ☐ New Hire	☐ Active ☐ COBRA ☐ State Continuation
Hours Worked per week	☐ Life Event/Date ______ ☐ Annual Open Enrollment	Start dt ___/___/___
	☐ Status Change _______	End dt ___/___/___
	☐ Dependent Add/Delete	☐ Hourly ☐ Salary
	☐ Change Name/Address ☐ Late Enrollee	☐ Union ☐ Non-Union ☐ Retired
	☐ Part Time to Full Time	☐ Other ______________________
	☐ Waiving Coverage ☐ Termination	
	☐ Other	

A. Employee Information | **If you are waiving all coverage, please complete sections A and B.**

Last Name	First Name	MI	Social Security Number/Tax Identification Number

Address	Apt #	City	State	ZIP Code	Home Phone
					Cell Phone

Date of Birth / /	Sex ☐ M ☐ F ☐ N	Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed Language preference, if not English ______________	Work Phone

Email Address:

To select paperless delivery complete and sign the enrollment form and provide your email address.
Check here to receive your required plan communications by mail ☐

Primary Care Physician[1] Existing Patient? ☐ Yes ☐ No
Physician first & last name
Address ______________________________
ID# _ _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

B. Waiver of coverage

I decline all 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.

Date	Employee Signature if waiving all coverage

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by Oxford Health Insurance, Inc.

Employee Name ____________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[2]	Last Name	First Name			
Spouse /Domestic Partner	Social Security Number/Tax Identification Number	ZIP Code	MI	Sex ☐ M ☐ F ☐ N	Date of Birth / /

Primary Care Physician[1] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# _ _ _ _ _ _ _ _ _ _ _ - _ _ _ _

Relationship[2]	Last Name	First Name			
Dependent	Social Security Number/Tax Identification Number	ZIP Code	MI	Sex ☐ M ☐ F ☐ N	Date of Birth / /

Primary Care Physician[1] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# _ _ _ _ _ _ _ _ _ _ _ - _ _ _ _

Relationship[2]	Last Name	First Name			
Dependent	Social Security Number/Tax Identification Number	ZIP Code	MI	Sex ☐ M ☐ F ☐ N	Date of Birth / /

Primary Care Physician[1] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# _ _ _ _ _ _ _ _ _ _ _ - _ _ _ _

Relationship[2]	Last Name	First Name			
Dependent	Social Security Number/Tax Identification Number	ZIP Code	MI	Sex ☐ M ☐ F ☐ N	Date of Birth / /

Primary Care Physician[1] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# _ _ _ _ _ _ _ _ _ _ _ - _ _ _ _

Relationship[2]	Last Name	First Name			
Dependent	Social Security Number/Tax Identification Number	ZIP Code	MI	Sex ☐ M ☐ F ☐ N	Date of Birth / /

Primary Care Physician[1] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ____________________

Address ____________________

ID# _ _ _ _ _ _ _ _ _ _ _ - _ _ _ _

(1) For products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (2) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet.

Employee name ____________________

D. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Benefit offerings are dependent upon employer selection.

Person	Medical
Employee	☐ __________
Spouse/Domestic Partner	☐
Dependent	☐

E. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ No ☐ Yes (if yes, please complete this section.)

Prior medical carrier name ____________________ Effective date ___/___/___ End date ___/___/___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

F. 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 MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
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

Are you receiving Social Security Disability Insurance (SSDI)? ☐ Yes ☐ No Start Date ___/___/___

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.
** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

G. 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. 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 understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare 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 application and any attachments.

Please note that if you make a material misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

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 or health-related procedures, products and 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.

Please maintain a copy of this authorization for your records. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. I (we) agree that this authorization, unless revoked earlier, is valid for 24 months from the date below.

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

Disclosures

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding HIV/AIDS, mental health (other than psychotherapy notes and substance use disorder records), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization for this disclosure of my medical, claim or benefit records is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 24 months after the date it is signed.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)