



A UnitedHealth Group Company

# Enrollment Application

for groups enrolling 10-50 employees only

Columbus 1(800) 225-7951

Cincinnati, Cleveland, Dayton 1(800) 281-2918

## United Healthcare of Ohio, Inc.

Non-Medical products provided by United Healthcare Insurance Company  
Non-Network benefits provided by United Healthcare Insurance Company of Ohio

PLEASE TYPE OR PRINT. ALL INFORMATION REQUIRED.

### TO BE COMPLETED BY EMPLOYER

### FOR PLAN USE ONLY

Group Number	Employee Hire Date	Dept #	Date Entered
Reason for Enrollment: <input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment			Processor
<input type="checkbox"/> COBRA (Reason for change: _____) <input type="checkbox"/> Other _____			Rate Class
Employee Status: <input type="checkbox"/> Actively Employed			Eff. Date
<input type="checkbox"/> Rehire <input type="checkbox"/> Retired <input type="checkbox"/> Other _____			
If applying for STD or X Salary Life: Employee's Monthly Salary _____			
Approved By:	Date		

### A. EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Birthdate	Sex	M F	Social Security Number
Street Address			City	State	Zip Code	County
Home Phone	Work Phone		Height/Weight	Marital Status	Single	Married
( )	( )			Widowed	Divorced	
Full Company Name			Branch/Division/Location	Occupation		

### B. FAMILY INFORMATION

List all family members to be covered. Write name as it should appear on I.D. card. Indicate coverage choice for each dependent.

Relationship	Coverage Selection	First Name	M.I.	Last Name	Social Security Number	Full-Time College Student	Resides with Employee*	Sex	Birthdate	Height/Weight
01 SPOUSE	Medical						YES	M	/ /	
	Dental						NO	F	/ /	
02	Medical					YES NO	YES	M	/ /	
	Dental					School Name:	NO	F	/ /	
03	Medical					YES NO	YES	M	/ /	
	Dental					School Name:	NO	F	/ /	
04	Medical					YES NO	YES	M	/ /	
	Dental					School Name:	NO	F	/ /	

\*If your dependent does not reside with you, or is 19 years or older and a full-time student in an accredited educational institution, please list the school they are attending above and their present address on a separate sheet of paper. Coverage will not be offered to dependents living outside of the service area, unless they are a full-time student as defined above or coverage is required by a court decree. If you are subject to provide health coverage for any of the dependents listed above, please provide a copy of the decree.

### C. PRODUCT SELECTION (Check all that apply)

<b>MEDICAL BENEFITS:</b>	<b>DENTAL BENEFITS:</b>	<b>WAIVER OF COVERAGE SECTION (Must be completed if employee and/or dependents waive either MEDICAL or DENTAL coverage)</b>
Employee Only	Employee Only	The reason I am not applying for the coverage(s) checked is: Please circle "medical" and/or "dental", if applicable.
Employee + Spouse	Employee + Spouse	
Employee + Child (ren)	Employee + Child (ren)	
Family Coverage	Family Coverage	
No Employee Coverage*	No Employee Coverage*	
No Dependent Coverage*	No Dependent Coverage*	Covered by spouse's group (medical) (dental) plan _____ (name of carrier)
		Covered by another (medical) (dental) plan _____ (name of carrier)

\*Must be checked if coverage is waived.

OTHER COVERAGES: Life/AD&D Dep Life STD

IF LIFE BENEFIT IS INCLUDED, PLEASE COMPLETE. Beneficiary Relationship

### D. OTHER HEALTH INSURANCE INFORMATION (This section must be completed)

#### PRIOR HEALTH CARE COVERAGE OF EMPLOYEE DURING THE PREVIOUS 12 MONTHS

Company (Companies)	Start Date of Prior Coverage(s)	End Date of Prior Coverage(s)
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On the day your coverage begins will any family members, including those not listed above, be covered by other health or dental insurance, Medicare or Medicaid?  
YES NO If yes, fill out this section. Use extra paper if more than one addition policy will be in force.

Coverage type:	Insurance Company Name, Address and Phone Number	Policy Number
Medical Insurance		
Dental Insurance		
Medicare		
Medicaid		
Policy Coverage Dates	Name of Policyholder	Policyholder's Birthdate
		Family Members Covered
Policyholder's Employer: Name	Address	Phone Number

Names of family members covered by Medicare Medicare Claim Number Part A Effective Date Part B Effective Date Is Medicare eligibility due to: Kidney failure Disability

