



UnitedHealthcare®

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

Group Name/Number

To Be Completed by Employer
Reason for Application
Product Selection
Employee Type

A. Employee Information
First Name, MI, Last Name, Social Security Number, Home Phone, Work Phone, Address, Apt #, City, State, Zip, Email Address

B. Family Information
List All Enrolling (Attach sheet if necessary)
Marital Status
Last Name, First Name, MI, Sex, Relationship, Birthdate, Height, Weight, Full Time, Physician\*

\*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents...

C. Product Selection
(Please check all that apply)\*
Person, Medical, Life, Sup Life, Sup AD&D, Dental, Vision, STD, LTD, Dual Option Plan Number

\*Benefit offerings are dependent upon employer election
Life Beneficiary's Full Name and Address, Relationship

D. Other Coverage Information
Has anyone on this application been covered with health benefits...
Are you or any of your dependents covered by Medicare?

E. Waiver of Coverage
Declining coverage due to existence of other coverage:
I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event...

F. Signature
I authorize United HealthCare Insurance Company and its affiliates ("The Company and Affiliates") to obtain, use and disclose my medical, claim or benefit records...

## F. Signature (continued)

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents, I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) 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. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applicable)
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## G. Medical History

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_ Group Name \_\_\_\_\_

Have you - or any person listed in section B "Family Information" on the front of this form - consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium.**

<b>1A Cancer/Tumor</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____
<b>1B Heart/Circulatory</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Skin Ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other _____
<b>1C Reproductive</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date____) <input type="checkbox"/> Multiples Expected (#____) <input type="checkbox"/> Pregnancy Complications (Current or Past) <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
<b>1D Intestinal/Endocrine</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Hiatal Hernia/Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other _____
<b>1E Brain/Nervous</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other _____
<b>1F Lung/Respiratory</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____
<b>1G Eyes/Ears/Nose/Throat</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____
<b>1H Urinary/Kidney</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
<b>1I Bones/Muscles</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Arthritis (Rheumatoid or Osteo) <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Pituitary Dwarfism <input type="checkbox"/> Pulled/Strained Muscle <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other Back/Neck Disorder <input type="checkbox"/> Other _____
<b>2 Mental Health/ Substance Abuse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other _____
<b>3 Transplant</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Organ _____
<b>4 Medication</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications <input type="checkbox"/> Medications Taken Within The Past Year
<b>5 Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition or Congenital Disorder Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised, But Not Yet Done <input type="checkbox"/> Unexplained Weight Change
<b>6 Tobacco</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anyone On This Application Used Tobacco Products In The Past 12 Months Name _____

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Prognosis