

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

**Groups with 2 to 9 employees**

## **Enrollment Application/Change/Cancellation Request for Medical Coverage**



**E. Other Medical Coverage Information / Waiver (This section must be completed)**

Have you or your dependents had any other medical coverage in the last 12 months?  YES  NO Will this coverage be terminated?  YES  NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date
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Coverage type:  Group Policy  Individual Policy  Medicare/Medicaid  Other \_\_\_\_\_

Is this coverage through your spouse's employer? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
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Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)
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Medicare effective date Parts A&B	Reason for Medicare eligibility: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease	Medicare Claim #
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**WAIVER** I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:  
 Existence of other health coverage  Spousal coverage  Other Reason (Explain) \_\_\_\_\_  
**Check one of the above boxes, then read and sign.**

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 and may apply at next open enrollment period. 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 dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information" located on the back of this form.

Employee  
 Signature \_\_\_\_\_ Date Signed \_\_\_\_\_  
 (only sign if you are waiving coverage)

**Medical History (applicable for groups of one to \_\_\_\_\_)**

Have you or your dependents been diagnosed, treated, received counseling or advice during the past 5 years for any of the following:  
**PLEASE CHECK AND EXPLAIN ALL THAT APPLY.**

**Cancer/Tumor**  Lung  Breast  Liver  Colon  Leukemia/Lymphoma  Melanoma  
 Yes  No **1**  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_ Stage/Level \_\_\_\_\_

**Heart/Circulatory**  High Blood Pressure  Stroke  Aneurism  Heart Disease  Hemophilia  Blood Disorder  Skin Ulcer  
 Yes  No **2**  Varicose Veins  Phlebitis  Congestive Heart Failure  Bypass/Angioplasty  
 Elevated Cholesterol/Triglycerides  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Reproductive** Current Pregnancy (due date \_\_\_\_\_)  Multiples expected \_\_\_\_\_  Pregnancy Complications (current or past)  
 Yes  No **3**  Infertility  Endometriosis  Breast Disorders  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Intestinal/Endocrine**  Gallbladder  Liver Disorder  Hepatitis B/C  Colon Disorder (provide diagnosis)  Crohn's/Ulcerative Colitis  
 Yes  No **4**  Diabetes  Ulcer  Chronic Pancreatitis  Hiatal Hernia/Reflux  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Brain/Nervous**  Multiple Sclerosis  Paralysis  Cerebral Palsy  Migraines  Parkinson's Disease  Alzheimer's Disease  
 Yes  No **5**  Other \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

**Immune**  Lupus  HIV+  AIDS  Other \_\_\_\_\_  
 Yes  No **6**  
 Patient Name \_\_\_\_\_ Date Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_  
 Date Last Treated \_\_\_\_\_ Current Status \_\_\_\_\_

Lung/Respiratory 7
Asthma Allergies Cystic Fibrosis Emphysema/Chronic Bronchitis
Pneumonia Tuberculosis Sleep Apnea Other
Patient Name Date Diagnosed Treatment
Date Last Treated Current Status

Eyes/Ears/ Nose/Throat 8
Retinopathy Cleft lip/palate Chronic Sinusitis Deviated Septum Acoustic Neuroma Glaucoma
Cataracts Chronic Ear Infections Other
Patient Name Date Diagnosed Treatment
Date Last Treated Current Status

Urinary/Kidney 9
Renal Failure Polycystic Kidney Disease Neurogenic Bladder
Kidney Stones Prostate Disorder Other
Patient Name Date Diagnosed Treatment
Date Last Treated Current Status

Bones/Muscles 10
Bulging/Herniated Disc Pituitary Dwarfism Spina Bifida Arthritis (Rheumatoid or Osteo) Joint Injury
Pulled/Strained muscle Other back/neck disorders Other
Patient Name Date Diagnosed Treatment
Date Last Treated Current Status

Mental Health/ Substance Abuse 11
Bipolar/Manic Depression Eating Disorder Anxiety/Depression Alcoholism Drug Abuse
Suicide Attempt Attention Deficit Disorder Other
Patient Name Date Diagnosed Treatment
Date Last Treated Current Status

Transplant 12
Organ Bone Marrow Surgery Completed (Date ) Discussed possible future transplant
Patient Name Rejections/Complications
Current Treatment
(Date ) Current Status

Medication 13
Current Medications Patient Name
Medication Name
Medications within the past year Patient Name
Medication Name Date Last Taken

Other 14
Treatment or surgery discussed or advised, but not yet done
Condition or Congenital Disorder not mentioned above
Abnormal test or physical results Unexplained Weight Change
Patient Name Date
Details

15 Has anyone on this application used tobacco products in the past 12 months? Name

IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SHEET AND BE SURE TO DATE AND SIGN THAT SHEET.

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate.
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 or Summary Plan Description.
I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or 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.
I acknowledge that I have received the "Important Information" statement which is included on the back of this form.
I understand that submission of an application or filing a claim containing a false or deceptive statement, with intent to defraud or to facilitate a fraud against an insurer, constitutes insurance fraud.

Date Employee Signature Spouse Signature (if possible) and applicable

OHIO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN OHIO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.

**IMPORTANT INFORMATION**

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials do not answer your questions. Further information is available at [www.uhc.com](http://www.uhc.com), at [www.myuhc.com](http://www.myuhc.com), at (800) 328-8835 – Columbus, (800) 468-5001 – Cleveland, (866) 351-6827 – Southwest Region, or through your employer contact.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
  - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
  - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

**Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage.**

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) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this form. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Medical Coverage. 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 Request for Medical Coverage 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.

HMO products provided by UnitedHealthcare of Ohio, Inc.

Medical insurance and non-network benefits provided by  
United HealthCare Insurance Company of Ohio

Life insurance benefits provided by United HealthCare  
Insurance Company

\*\*\*Dental Benefits provided by Dental Benefit Providers, Inc. and  
affiliates United HealthCare Insurance Company