Enrollment/Change Form

Critical Illness Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare

TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:
Employer Authorization:	Date of Hire: ______	Location:
Requested Effective Date of Coverage / Date of Change: ______		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Civil Union*
☐ Divorce	☐ Dissolution Of Civil Union	☐ Death	☐ Birth
☐ Adoption/Legal Custody	☐ Court Ordered Dependent		
☐ Other:		Start Date __/__/__	End Date __/__/__

EMPLOYEE INFORMATION

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Employer Assigned ID#		Date of Birth:
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:

Home Phone:	Work Phone:	Email Address:	Annual Salary:

Sex: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Domestic Partner * ☐ Party to Civil Union*

Number of hours worked per week: ______

Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

FAMILY INFORMATION **Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)**

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___	☐ M ☐ F	☐ Spouse ☐ Domestic Partner* ☐ Civil Union*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___	☐ M ☐ F	Dependent	☐Yes ☐No

*Domestic Partner or Civil Union coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation.

** For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

BENEFIT ELECTIONS

Person	Critical Illness	Monthly Rate		
Employee	☐ $_____	☐ $_____		
Employee + Spouse	☐ $_____	☐ $_____		
Employee + Child(ren)	☐ $_____	☐ $_____		
Employee,Spouse &Child(ren)	☐ $_____	☐ $_____		

BENEFICIARY(IES) *

Beneficiary(ies) to be designated at time of Enrollment.

Product	Full Name		%	Address	City	State	Zip Code	Relationship
Critical Illness	Primary							
	Secondary/ Contingent							

* Do not use to change a previously designated Beneficiary. For changes, use the Beneficiary Designation form available from the Employer.

AUTHORIZATION AND ACKNOWLEDGEMENT

Form must be signed

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

Employee/Enrollee Signature:	Date: