

GROUP ENROLLMENT/CHANGE CANCELLATION FORM



ACTION (COMPLETE APPLICABLE BOX BELOW)

New Enrollment/Additions: (check one)

New Hire

Open Enrollment

Status Change (PT to FT) on ____/____/____

Return from Leave/Layoff on ____/____/____

Birth on ____/____/____

Marriage on ____/____/____

Adoption (attach legal document)

Other (describe) _____

Requested Effective Date of Enrollment _____

Cancellations:

Cancel all coverage

Cancel dependents listed below in Section D

Reason: (check one)

Death Employee Termination

Divorce Moved out of service area

Dependent reached student/dependent max age

Other (describe) _____

If COBRA participant, start date _____ stop date _____

Requested Effective Date of Cancellation _____

Change:

Street Address To: _____

Home Phone To: _____

Name To: _____

Electing Continuation Coverage

Change in Other Health Insurance Information (complete E)

Other (describe) _____

Requested Effective Date of Change _____

EMPLOYEE INFORMATION

Name _____ M.I. _____ Last Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____ Home Phone (____) _____ Work Phone (____) _____

M F Date of Birth _____ Marital Status Married Single Date of Hire _____ Full Time Part Time

COVERAGE SELECTION

Who to enroll:

Employee Only Employee/Spouse Employee/Children Employee/Spouse/Children None. Waive Coverage

FAMILY INFORMATION

Employee and dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Employee/Dependent Social Sec. No.	Last Name	First Name	M.I.	Birthdate	Relationship	Sex (M or F)	Full-Time College Student
enroll						SPOUSE		
cancel								<input type="checkbox"/> YES <input type="checkbox"/> NO School Name: _____
change								<input type="checkbox"/> YES <input type="checkbox"/> NO School Name: _____
change								<input type="checkbox"/> YES <input type="checkbox"/> NO School Name: _____

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 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 age is required by a court decree. If you are subject to a court decree to provide health coverage for any of the dependents listed above, please provide a copy of the decree.

OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins will any family members, including those not listed above, be covered by other health or dental insurance or Medicare?

YES NO If yes, fill out this section. Use extra paper if more than one additional policy will be in force.

Age Medical Insurance Dental Insurance Medicare (see below)

Insurance Company Name and (Area Code) Phone Number _____ Policy Number _____

Coverage Dates _____ Name of Insured _____ Insured's Date of Birth _____ Insured's Employer Name _____

Names of family members covered by Medicare _____

SIGNATURE (FORM MUST BE SIGNED)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone, enrolled on or added to this application (I/We), I authorize any health care professional or entity to give United HealthCare Insurance Company of New York and the employer or any of their agents, any and all records or information as permitted by law pertaining to medical history or services rendered to US for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.

Employee Signature _____ Date Signed _____

EMPLOYER AUTHORIZATION

Company Name _____ Date of Employment _____ Group Policy Number _____ Position _____ Date _____