

CALIFORNIA Small Business Employee Enrollment Form

(DO NOT STAPLE)



Unimerica Insurance Company

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Group Name/Number

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

To Be Completed by Employer		
Requested Effective Date of Insurance/Health Plan Coverage/Date of Change / /	Reason for Application <input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Termination Date: ____/____/____ <input type="checkbox"/> Waiving Coverage (Complete Sections A, B, and G) <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Other _____	Employee Type (check all that apply) <input type="checkbox"/> Active <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____ <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA Start Date ____/____/____ End Date ____/____/____
Date of Hire / /		Indicate Qualifying Event _____
Position/Title		Original Qualifying Event Date Start Date ____/____/____ End Date ____/____/____
Hours Worked Per Week		
Salary \$ _____ <small>Required only if Life Plan based on salary.</small>		

A. Employee Information		Complete All Sections			
Last Name	First Name	MI	Social Security Number	Home Phone	Work Phone
Address		Apt #	City	State	Zip Code
E-mail Address					
Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	Permanently Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Physician* (First & Last Name)/ID# Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist* (First & Last Name)/ID# Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	

B. Dependent Information		List All Enrolling (attach sheet if necessary)				
Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Spouse/ Domestic Partner	Birth Date	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physician: ID#: Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist: ID#: Existing Patient (Dental) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		
Social Security Number				Weight		
Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Dependent	Birth Date	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No	Physician: ID#: Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist: ID#: Existing Patient (Dental) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		
Social Security Number				Weight		
Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Dependent	Birth Date	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No	Physician: ID#: Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist: ID#: Existing Patient (Dental) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		
Social Security Number				Weight		

*IMPORTANT: Please use the PacifiCare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. **For court-ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status.

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B. Dependent Information (continued)

Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Dependent	Birth Date	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physician: ID#: _____ Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		
Social Security Number				Weight		

C. Product Selection Check the box for each plan you or your dependents are enrolling in; Indicate the dollar amount selected for the life and AD&D plans. Benefit offerings are dependent on employer selections. Indicate the medical and dental plan enrollees are selecting.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____		
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____		

Medical Plan Selection – Medical Plan Selection: Check the box and write in the Plan Code or Description you wish to enroll in. Check with your employer for available benefit plans.
 UnitedHealthcare Plan Code: _____
 PacifiCare Plan Description: _____

Dental Plan Selection – Write in the Plan Code you wish to enroll in. Check with your employer for available benefit plans.
 Code: _____
 FOR MEDICAL PLEASE CHOOSE: A) UHC \$500 W/ PLAN CODE 5E-F
 B) UHC \$1000 W/ PLAN CODE 5E-Q OR C) PCC HMO W/ PLAN CODE PD-0

D. Prior Medical Insurance/Health Plan Coverage Information This section must be completed to receive credit for prior medical insurance/health plan coverage.

Have you or your dependents ever been a UnitedHealthcare or PacifiCare member? Yes No
 Within the last 12 months, have you, your spouse/domestic partner, or your dependents had any other medical insurance/health plan coverage? NO YES (if yes, please complete this section.)
 Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___
 Prior insurance/health plan coverage type: Employee Spouse/Domestic Partner Child(ren) Family

E. Other Medical Insurance/Health Plan Coverage Information This section must be completed. (Attach sheet if necessary.)

On the day this insurance/health plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical insurance/health plan coverage, including another UnitedHealthcare plan or Medicare?
 YES (continue completing this section) NO (If NO, then skip the rest of the Other Medical Insurance/Health Plan Coverage section.)
 Name of other carrier _____

Other Group Medical Insurance/Health Plan Coverage Information (only list those covered by other plan)	Type (B/S/F) [†]	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder/covered employee for other insurance/health plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

[†]B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).
 S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
 F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):

Medicare – Employee/Spouse/Domestic Partner/Dependent Name: _____
 Medicare ID# _____ (Please attach a copy of your Medicare ID card.)

Enrolled in Part A: Effective Date ___/___/___ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date ___/___/___ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date ___/___/___ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Disabled Disabled but actively at work

Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work
 Are you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date ___/___/___
 *Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

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F. Other Dental Insurance/Coverage Information **This section must be completed. (Attach sheet if necessary.)**

On the day this dental plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other dental insurance/coverage, including another UnitedHealthcare plan?

YES (continue completing this section) NO (If NO, then skip the rest of the Other Dental Insurance/Coverage section.)

Name of other carrier _____

Other Dental Insurance/Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder/covered employee for other dental plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).
 S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
 F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

G. Waiver of Coverage **Complete only if you are waiving coverage for yourself and/or any family member.**

I decline coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents	Declining coverage reason: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> COBRA/CAL-COBRA/AB-1401 from Prior Employer <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Tri-Care <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Other _____
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I acknowledge that the available coverages have been explained to me by my employer and I know that I have been given the right and have been given the chance to apply for coverage. I have decided not to enroll myself and/or my dependent(s), if any.

I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in my employer health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THE GROUP MEDICAL AND/OR LIFE INSURANCE PLAN AND THERE MAY BE A SIX-MONTH PRE-EXISTING CONDITION EXCLUSION UNLESS I AND/OR MY DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE. THE TWELVE (12)-MONTH WAIT WILL NOT APPLY IF I AND/OR MY DEPENDENTS ARE ENTITLED TO AN OFF-CYCLE ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.)**

- The twelve (12)-month wait will not apply if:
1. I certify at the time of initial enrollment that the coverage under another employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, and I lose coverage under that employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal;
 2. my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period;
 3. a court orders that I provide coverage under this plan for a spouse or minor child; or
 4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 30 days after the marriage, domestic partnership, birth, adoption or placement for adoption.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be declined coverage entirely.

Employee Signature (only if waiving coverage for self and/or dependents)	Date _____/_____/_____
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H. Authorization to Release Medical Information and Application Signature

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records (my "Confidential Health Information"). I understand my Confidential Health Information may contain information created by other persons or entities (including health care providers) as well as information regarding drug and alcohol use, HIV/AIDS, mental health treatments (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer, health care service plan or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, who are in possession of my Confidential Health Information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my Confidential Health Information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment and rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

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) understand that UnitedHealthcare and Affiliates 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. Please maintain a copy of this authorization for your records.

Employee Signature	Employee Name (please print)	Date ____/____/____
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I. Binding Arbitration

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE § 1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. SEC. 1, ET SEQ.

Employee Signature (required)	Employee Name (please print) (required)	Date (required) ____/____/____
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J. Census Information

NOTE: Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: White Black, African-American Native Hawaiian/Pacific Islander Hispanic/Latino
 American Indian/Alaska Native Asian Other Race, please specify _____

Coverage provided by "UnitedHealthcare and Affiliates": Medical coverage provided by UnitedHealthcare Insurance Company. Dental coverage provided by UnitedHealthcare Insurance Company, Unimerica Insurance Company, PacifiCare Life and Health Insurance Company, or Dental Benefit Providers of California, Inc. Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company. Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company.

Insurance coverage provided by or through UnitedHealthcare Insurance Company, underwritten by PacifiCare Life and Health Insurance Company or their affiliates. Medical coverage provided by PacifiCare of California and PacifiCare Behavioral Health of California, Inc. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc., PacifiCare Health Plan Administrators, Inc. or their affiliates. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.