

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

**Groups with \_\_\_\_\_ to \_\_\_\_\_ employees**

## **Enrollment Application/Change/Cancellation Request**

**Hawaii**

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

- Enroll, Cancel, Change, Address Change, Name Change, Date of Change

A. Employee Information

Form for Employee Information including fields for First Name, Last Name, Social Security #, Street Address, Home Phone, Work Phone, Marital Status, Sex, Birthdate, Height/Weight, Physician, etc.

B. Family Information

Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Table with columns for dependent information: Last Name, First Name, M.I., Sex, Birthdate, Relationship, Height/Weight, Full-Time Student, Physician, and Are you a Current Patient?

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

C. Product Selection (check all that apply)

Form for Product Selection including MEDICAL BENEFITS, DENTAL BENEFITS, LIFE INSURANCE PRODUCTS, and EMPLOYER USE ONLY.

OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)

D. To Be Completed By Employer

Form for Employer completion including Company Name, Group #, Plan Variation, Medical/Dental, Department Number, New Enrollment/Additions, and Cancellations.

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information.

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

Applicant Name \_\_\_\_\_

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

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

Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)

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 #

**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.

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

**F. Medical Research Studies / Additional Products & Services**

- Please do not send me information regarding medical research studies.  
 Please do not send me information regarding additional products and/or services.

**Medical History**

Yes  No 1. Have you or your dependents visited a health care professional including inpatient or outpatient hospitalization in the past 5 years for any illness, injuries, medical condition or surgery (including mental health, chemical dependency and infertility)? If yes, list person's name, dates, reason for and results of the treatment.

Yes  No 2. Have you or your dependents been prescribed or taken any prescription medications for more than 30 days in the past 12 months? If yes, list person's name, name of drug, reason for prescribing medication and dates taken.

**Continued on next page**

White - Health Plan Copy

Canary - Health Plan Copy

Pink - Employer Copy

Goldenrod - Employee Copy

**Medical History (continued)**

Yes  No 3. Are you or your dependents aware of any condition, illness or injury that may require (ongoing or future) surgery or treatment of any type, or has any surgery or treatment been recommended that has not yet been performed?

Yes  No 4. Are you or your dependents currently pregnant? If yes, list person's name, expected delivery date and any complications including the anticipation of multiple births.

Yes  No 5. Has anyone on this application used tobacco products in the past 12 months?

**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 there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

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.

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Date \_\_\_\_\_ Employee Signature \_\_\_\_\_

Spouse Signature (if possible) and applicable \_\_\_\_\_

**HAWAII INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN HAWAII TO SMALL EMPLOYERS OF 1-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, 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. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

**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.myuhc.com](http://www.myuhc.com), through your employer or broker.

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 insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the 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 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 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.

Group Medical Insurance provided by or through  
United HealthCare Insurance Company  
Dental Benefits provided by:  
\*\*\*Dental Benefit Providers, Inc., and affiliates