

Enrollment/Change Form

Group Basic Life and Basic AD&D Insurance and Supplemental Life and AD&D Insurance provided by:

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



TO BE COMPLETED BY EMPLOYER

Employer Name: Archdiocese of Dubuque		Policy Number:		
Employer Authorization:	Date of Hire: _____	Class:		
	Plan Variation/Reporting Code:	Plan:		
Requested Effective Date of Coverage / Date of Change: _____		<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change		
Reason: (Check the Appropriate Boxes)	<input type="checkbox"/> New Group Plan	<input type="checkbox"/> New Hire	<input type="checkbox"/> Annual Open Enrollment	<input type="checkbox"/> Address Change
	<input type="checkbox"/> Name Change	<input type="checkbox"/> Employee Terminated	<input type="checkbox"/> Marriage	<input type="checkbox"/> Civil Union*
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Dissolution Of Civil Union	<input type="checkbox"/> Death	<input type="checkbox"/> Birth
	<input type="checkbox"/> Adoption/Legal Custody	<input type="checkbox"/> Court Ordered Dependent	<input type="checkbox"/> Cobra/State Continuation	
	<input type="checkbox"/> Other:		Start Date ___/___/___	End Date ___/___/___

EMPLOYEE INFORMATION

SS# _____ - _____ - _____		Employer Assigned ID#	Date of Birth:
Last Name:		First Name:	Middle Initial:
Address:		City:	State:
Home Phone:	Work Phone:	Email Address:	Annual Salary:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Party to Civil Union*		
Number of hours worked per week: _____			
Employee Type (Check all that apply): <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Retired <input type="checkbox"/> Other			

FAMILY INFORMATION

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

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

*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.

Employee Name Last:		First:	Middle Initial:	Date of Birth:
BENEFIT ELECTIONS				
Person	Basic Life and AD&D	Supplemental Life		Supplemental AD&D
Employee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> Waive	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Waive
Spouse (or Domestic Partner)		<input type="checkbox"/> \$ _____	<input type="checkbox"/> Waive	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Waive
Dependent Child(ren)		<input type="checkbox"/> \$ _____	<input type="checkbox"/> Waive	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Waive

BENEFICIARY(IES)*		Beneficiary(ies) to be designated at time of Enrollment.					
Product	Full Name	%	Address	City	State	Zip Code	Relationship
Life & AD&D	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
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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. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

Employee/Enrollee Signature:	Date:
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Fraud Warning Notices	Please review the notice that applies in your state.
<p>For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.</p> <p>For residents of Connecticut: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.</p>	

For residents of Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kansas: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of fraud as determined by a court of law.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties

For residents of Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.