Global Insurance
Enrollment Application/Change/Cancellation Request

UnitedHealthcare Global

P.O. Box 740111
Atlanta, GA 30374-0111
Fax: 877-370-4150

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**
Medical _____ Vision _____ Dental _____	Medical _____ Vision _____ Dental _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___
If non- U.S. Citizen - Employee Number _____
Requested Date of Coverage ___ /___ /___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date_____
☐ **Annual Open Enrollment**
Requested Effective Date of Enrollment ___ /__ /___

☐ **Cancellations:** Last Date of Employment ___ /___ /___
Requested Effective Date of Cancellation ___ /___ /___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Signature	Date
Employer Position	Phone

A. Employee Information

Social Security Number (US only)	Birthdate / / MM DD YYYY	Sex ☐M ☐F	Last Name	First Name	MI

Assignment Residence Address | Apt# | City/Town | State/Region | Area Postal Code | Country

Home Phone | Work Phone | Cell Phone

Race – Check all that apply (Optional)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify

Preferred Mailing Address ☐ Check if same as above

Street Address | Apt# | City/Town | State/Region | Area Postal Code | Country

Other information:

E-mail Address	Preferred Communication Type: ☐ E-mail ☐ Phone ☐ Mail	Resident of

Language preference if not English	Citizen of

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Global Company
Dental coverage provided by UnitedHealthcare Global Company
Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Global Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Global Company

M48797-C 9/14

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | ☐ Spouse ☐ Domestic Partner (if eligible) | Birthdate / / MM DD YYYY

Preferred mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_| | Dependent Citizenship Country: | Race – Check all that apply (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent | Birthdate / / MM DD YYYY

Preferred mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_| | Dependent Citizenship Country: | Race – Check all that apply (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent | Birthdate / / MM DD YYYY

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_| | Dependent Citizenship Country: | Race – Check all that apply (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent | Birthdate / / MM DD YYYY

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_| | Dependent Citizenship Country: | Race – Check all that apply (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent | Birthdate / / MM DD YYYY

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_| | Dependent Citizenship Country: | Race – Check all that apply (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

* Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their health and well-being and not for eligibility or claim payment determination.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	LTD	Life	ADD	Dual Option Selected
Employee	☐	☐	☐	☐	☐ $_____	☐	☐
Spouse	☐	☐	☐		☐		
Domestic Partner	☐	☐	☐		☐		
Dependents	☐	☐	☐		☐		
					Salary______ Required only if Life Plan based on salary		

Life Insurance Beneficiary's Full Name and Address | Relationship

D. Reimbursement options

Pay Member

☐ Use banking details on file ☐ Payment by check ☐ Electronic funds transfer payment

Specify currency for reimbursement _____ Note - If no selection, reimbursement will default to a US dollar check

For bank transfers please complete the following:

Bank name _____

Bank address _____

SWIFT / BIC Code _____

Beneficiary routing code _____

Account number / IBAN _____

Account name / Payee _____

E. Other Medical or Other Country Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse, domestic partner or any of your dependents be covered under any other medical or country health plan or policy, including another UnitedHealthcare plan or Medicare?

☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier or other country coverage:

Other Group Medical or Other Country Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

* B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (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.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Domestic Partner
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

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. 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.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage) (Spouse may include a Domestic Partner, depending on your benefit plan)

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, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care 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 provider 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, and 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 provider'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 provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider 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 coverage.

I (we) request the indicated group 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 health history, condition, or treatment of any persons named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for health 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 below. 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 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 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 Coverage and any attachments.

M48797-C 9/14