



# GROUP MEMBERSHIP ENROLLMENT FORM

## WORKSHEET INSTRUCTIONS

— PLEASE PRINT —

**Section 1 Employee Information**

Please fill in requested information

**Section 2 Employee and Family Information**

Please fill in requested information

Please check the appropriate boxes

**Section 3 Coverage Election**

Please fill in requested information

Please check the appropriate boxes

**Section 4 Coordination of Benefits Information**

Please fill in requested information

Please check appropriate box

**Section 5 Beneficiary Information**

Please fill in requested information if you have elected life coverages

Please check the appropriate boxes indicating beneficiary designation

Please provide all necessary details specific to beneficiary designation

**Section 6 Employee Authorization**

Please sign, date, and return form to your employer.

**UniCare Copy** - Send White copy to UniCare for processing

**Employee Copy** - Retain the Yellow copy for your records

This application is for the purpose of enrolling in health, dental and other non-health products such as life and disability coverage. The information on this application, except for health history and health status, will be shared with the non-health components of UniCare for the purpose of underwriting, maintaining enrollment and billing services.

UniCare Health Plans of the Midwest, Inc. (IL and IN only)

**Type of Enrollment**

UniCare Health Insurance Company of the Midwest (IL and IN only) • UniCare Life and Health Insurance Company

Open Enrollment    New Hire    \*HIPAA Special Enrollee    Re-Enrollee (rehired within one year)    Late Enrollee    COBRA

**HIPAA Verification** - Check here if you have no creditable coverage at any time during the last twelve months, or have had a significant break in service i.e., (a period of 63 consecutive days during which you have not had any creditable coverage).

\* HIPAA Special Enrollees: If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after date of the marriage, birth, adoption, or placement for adoption, regardless of whether you had other health coverages.

**1. Employee Information**

★ Name of Policyholder (Employer)		Bill/Reference (if applicable)	Case Number
Name of Employee LAST		Bill Subgroup (if applicable)	Dept Number (if applicable)
FIRST M.I.		Class (if applicable)	Employee/Clock Number (if Applicable)
★ Home Address		Employment Status ★ Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/>	Daytime Phone Number
★ City/State/Zip Code		COBRA Effective Date (Mo/Day/Yr)	Claim Category (if applicable)
★ Date of Hire / Rehire (Mo/Day/Yr)		COBRA Qualifying Event	Retirement Date (Mo/Day/Yr)

**2. Employee and Family Information** (Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary).

	NAME (Last, First, Mi)	NETWORK NAME / ID	★ SEX M-Male F-Female	★ DATE OF BIRTH (Mo/Day/Yr)	FULL TIME STUDENT (if 19 or older)	★ SOCIAL SECURITY NUMBER
★ Employee			M <input type="checkbox"/> F <input type="checkbox"/>		N/A	
Spouse			M <input type="checkbox"/> F <input type="checkbox"/>		N/A	
Dependent			M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**3. Coverage Election** Complete the boxes by checking (✓) to indicate your Coverage Elections and effective dates of coverage. All coverages listed may not be offered under your plan.

<input type="checkbox"/> Check here if you are declining coverage because of other health coverage. If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverages end.  To elect dependent coverage, the corresponding employee coverage must be elected.  Annual Earnings (If electing Life coverage) \$ _____  <b>NOTE: Dependent Life payments are always paid to employee.</b>  <b>** Please provide dollar amount in Effective Date Box.</b>	<b>COVERAGE</b>	<b>EFFECTIVE DATE</b>	<b>EMPLOYEE</b> Elected   Refused		<b>SPOUSE</b> Elected   Refused		<b>CHILDREN</b> Elected   Refused		<b>SUFFIX</b> (if applicable)
	Medical		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M _ _ _ _
	Drug Service		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R _ _ _ _
	Dental		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O _ _ _ _
	Vision		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	V _ _ _ _
	Basic Life		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C _ _ _ _
	Basic AD&D		<input type="checkbox"/>	<input type="checkbox"/>					B _ _ _ _
	Dep. Life		<input type="checkbox"/>	<input type="checkbox"/>					F _ _ _ _
	**Supp. Life	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>					S _ _ _ _
	Supp. AD&D		<input type="checkbox"/>	<input type="checkbox"/>					N _ _ _ _
	Exec. Supp.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E _ _ _ _
	STD		<input type="checkbox"/>	<input type="checkbox"/>					W _ _ _ _
	LTD		<input type="checkbox"/>	<input type="checkbox"/>					L _ _ _ _
HRA		<input type="checkbox"/>	<input type="checkbox"/>						
HSA		<input type="checkbox"/>	<input type="checkbox"/>						

UNIAccount (Flexible Spending Account)    Health Care Account \$ \_\_\_\_\_  
 (Indicate Payroll Deductions)    Dependent Care \$ \_\_\_\_\_  
 I authorize payroll deductions on the following: \_\_\_\_\_

\*UniCare Drug and Dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another Health Plan. Reminder Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursement expenses on your income tax return.

I certify that I have selected the above medical plan option and that I fully understand the terms and conditions of this plan. Moreover, I understand that I shall remain a member for a period of at least one year or until the next open enrollment period, after which I may elect to change medical plans during the 31 day open enrollment period.

#### 4. Coordination of Benefits Information

Do you or any dependents in your immediate family have other medical or dental insurance?

\_\_\_ No If "No" is checked, then proceed to Section 6 below, no other information in this section needs to be completed.

\_\_\_ Yes If "Yes" is checked, please complete the following information for the person(s) who has/have other insurance coverages.

Family Members Covered Under Other Insurance:  Self  Spouse  Child(ren)

Name of Insured \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

(Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_

Names of Covered Members \_\_\_\_\_

Name of Other Insurance Carrier \_\_\_\_\_ Effective Date: \_\_\_\_\_ Group No. \_\_\_\_\_

(Street Address) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Coverage Provides Benefits For:

**Mental Condition** \_\_\_ No \_\_\_ Yes **Hospital** \_\_\_ No \_\_\_ Yes **Dental** \_\_\_ No \_\_\_ Yes **Medical** \_\_\_ No \_\_\_ Yes **Medicare No.** \_\_\_\_\_

**Eff Date Part A** \_\_\_\_\_ **Eff Date Part B** \_\_\_\_\_ **Eff Date Part D** \_\_\_\_\_

**Medicare Entitlement Reason** \_\_\_ **Over 65** \_\_\_ **Disabled** \_\_\_ **ESRD** (End Stage Renal Disease) \_\_\_ **IRCT** (Insufficiencia Renal Crónica Terminal) \_\_\_ **ALS**

Do you, your spouse or dependent have Medicare or other insurance coverage? \_\_\_ Yes \_\_\_ No.

If yes, please complete and attach the Medicare Secondary Payer Status Form for Employees. This may be obtained through your employer.

Do you have an impairment affecting your ability to Communicate or Read? \_\_\_ Yes \_\_\_ No. If yes, please contact a UniCare representative.

Primary Language: English \_\_\_ Spanish \_\_\_ Other \_\_\_\_\_

#### 5. Beneficiary Information (Use form GA3434 for multiple beneficiaries.)

*Primary Beneficiary - First to Receive Payment (required) - If more than one beneficiary is named, enter a % for each.*

- Named Individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)  
 Estate of Insured  
 Revocable of Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)  
 Trustee Under Insured's Will (If choosing this option - DO NOT enter additional names in the Primary Beneficiary field.)

*Secondary Beneficiary - Second to Receive Payment (optional) - If more than one beneficiary is named, enter a % for each.*

- Named Individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)  
 Estate of Insured  
 Revocable of Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)  
 Trustee Under Insured's Will (If choosing this option - DO NOT enter additional names in the Secondary Beneficiary field.)

#### 6. Employee Authorization

I hereby apply for the insurance for which I am now or may become eligible under the group policy or policies issued to the policyholder by UniCare entity selected herein. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance, which authorization may be revoked by me at any time by prior written notice to the policyholder subject to the terms stated here and the insurance coverage I elected. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I apply again for insurance in accordance with the terms of the group policy. To the best of my knowledge and belief, the information I have provided on the form is complete and correct.

I authorize payment of medical benefits to preferred providers, where applicable, for those charges covered by my group insurance benefits. I authorize release, to or by my physician or healthcare provider or the UniCare entities identified herein of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits or other administrative purposes. I authorize any educational institution to furnish my employer or insurance carrier with information necessary to establish student eligibility. These authorizations shall remain valid for a period of 30 months from the date of this application. In the event I renew my insurance coverage at any time after the date of this application, I agree that such renewal(s) shall be considered a renewal and reaffirmation of the authorizations stated here for an additional 30 month period from the date of the most recent insurance coverage renewal. I or my authorized representative may request a copy of this authorization and a photocopy of this authorization shall be considered valid.

If you decline coverage for reasons other than having other health insurance coverage, and you wish to apply for these coverages at a future date, you will then have to comply with the rules governing late applicants.

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 may be guilty of insurance fraud.

During the term of my coverage under the Policy, I agree to provide my employer and/or UniCare with up-to-date information if I or my spouse, become entitled to Medicare benefits wherein Medicare is the primary payer in accordance with the federal Medicare As Secondary Payer (MSP) regulations.

EMPLOYEE'S SIGNATURE	DATE
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UniCare's PPO and Prescription Drug Plan are benefits products that may be offered in Illinois and Indiana by UniCare Health Insurance Company of the Midwest, in Texas by UniCare Health Insurance Company of Texas in all 50 states, Puerto Rico, and the District of Columbia by UniCare Life and Health Insurance Company. UniCare's Dental, Life and Disability benefits products are offered by UniCare Life and Health Insurance Company. UniCare's Flexible Spending Accounts and COBRA services are administered by UniCare Life and Health Insurance Company.

This application is for the purpose of enrolling in health, dental and other non-health products such as life and disability coverage. The information on this application, except for health history and health status, will be shared with the non-health components of UniCare for the purpose of underwriting, maintaining enrollment and billing services.