

Enrollment Application and Change Form
PLEASE PRINT CLEARLY



- NEW COVERAGE**
 REQUEST FOR CHANGE

1 EMPLOYEE INFORMATION											
LAST NAME		FIRST NAME			MI	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH		SOCIAL SECURITY NUMBER		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
HOME ADDRESS					CITY		STATE	ZIP CODE		HOME PHONE NUMBER () ()	
EMPLOYER NAME Anglican Church in North America		NAME OF CHURCH:					Effective Date:		WORK PHONE NUMBER () ()		

2 WAIVER / TERMINATION OF COVERAGE	3 WHO SHOULD BE COVERED	5 OTHER INSURANCE																
<input type="checkbox"/> I DECLINE COVERAGE FOR MYSELF <input type="checkbox"/> I DECLINE COVERAGE FOR MY DEPENDENTS-- REASON: <input type="checkbox"/> COVERED UNDER ANOTHER PLAN <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> TERMINATION OF COVERAGE: LIST PERSONS TO BE TERMINATED IN SECTION 6	<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE & Spouse <input type="checkbox"/> EMPLOYEE & Child(ren) <input type="checkbox"/> EMPLOYEE & FAMILY	<p>On the day your coverage begins, will any family members including those not listed below, be covered by any other health benefit plan, health, Medicare or Medicaid? Is another person legally responsible for coverage for your children? If you answered yes to either of these questions above, please complete the following:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">PERSON'S NAME WITH OTHER HEALTH PLAN</td> <td colspan="2">SOCIAL SECURITY NUMBER</td> </tr> <tr> <td>DATE OF BIRTH</td> <td>SEX</td> <td colspan="2">OTHER COMPANY'S NAME AND PHONE #</td> </tr> <tr> <td colspan="4">OTHER COMPANY'S POLICY NUMBER AND EFFECTIVE DATE</td> </tr> <tr> <td>MEDICARE NUMBER</td> <td>PART A EFFECTIVE DATE</td> <td colspan="2">PART B EFFECTIVE DATE</td> </tr> </table>	PERSON'S NAME WITH OTHER HEALTH PLAN		SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX	OTHER COMPANY'S NAME AND PHONE #		OTHER COMPANY'S POLICY NUMBER AND EFFECTIVE DATE				MEDICARE NUMBER	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	
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EMAIL ADDRESS: <i>*Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered late enrollees if you enroll in this plan at a later date.</i>		4 PLAN SELECTION <input type="checkbox"/> HSA OPTION #1 (BAGD- mod) <input type="checkbox"/> HSA OPTION #2 (BAHG) <input type="checkbox"/> PPO OPTION #4 (BALQ) <input type="checkbox"/> VISION <input type="checkbox"/> DENTAL																

6 COVERAGE INFORMATION										
(A) ADD (T) TERM (C) CHG	LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	ZIP CODE	DATE OF BIRTH (MO/DAY/YR)	SEX	OTHER INSURANCE	HANDI-CAPPED	FULL TIME STUDENT OVER 19?
	EMPLOYEE						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	SPOUSE						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	CHILD-1						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	CHILD-2						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	CHILD-3						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

7 AUTHORIZATION
<p>On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give The United HealthCare Insurance Company and its affiliates (and the employer) or any of their designees ("United HealthCare"), any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependent's coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.</p> <p>If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.</p> <p align="center">NOTICE OF ENROLLMENT RIGHTS</p> <p>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. I further understand that if I decline enrollment for myself or 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 dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.</p> <p>Health insurance or medical services benefits provided or administered by The United HealthCare Insurance Company, Hartford, CT.</p> <p>X Signature _____ Date _____</p>

8 TO BE COMPLETED BY EMPLOYER						
DATE OF HIRE	DATE SUBMITTED	EFFECTIVE DATE	POLICY NUMBER 919435	Division	REPORTING CODE/BRANCH	EMPLOYER SIGNATURE