❑ **NEW COVERAGE**
❑ **REQUEST FOR CHANGE**

Enrollment Application and Change Form
PLEASE PRINT CLEARLY

UNITEDhealthcare℠

1 EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS
			❑ MALE ❑ FEMALE			❑ SINGLE ❑ MARRIED

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER
				( )

EMPLOYER NAME	GROUP NUMBER				WORK PHONE NUMBER
Magnificus Corporation	918718				( )

2 WAIVER

❑ I DECLINE COVERAGE FOR MYSELF
❑ I DECLINE COVERAGE FOR MY DEPENDENTS

REASON:
❑ COVERED UNDER ANOTHER PLAN
❑ OTHER: _____

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.

3 WHO SHOULD BE COVERED

❑ EMPLOYEE ONLY
❑ EMPLOYEE & SPOUSE
❑ EMPLOYEE & CHILD(REN)
❑ EMPLOYEE & FAMILY

4 PLAN SELECTION

❑ 1. Choice Plus HSA BVLL Plan
❑ 2. Choice Plus BCDJ Plan
❑ 3. Choice Plus J64L Plan

5 OTHER INSURANCE

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:

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

6 COVERAGE INFORMATION

(A) ADD (T) TERM (C) CHG	LAST NAME FIRST NAME MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MO/DAY/YR)	SEX	OTHER INSURANCE	HANDI-CAPPED	FULL TIME STUDENT OVER 19?
	Employee			❑ MALE ❑ FEMALE	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N
	Spouse			❑ MALE ❑ FEMALE	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N
	Child-1			❑ MALE ❑ FEMALE	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N
	Child-2			❑ MALE ❑ FEMALE	❑ Y ❑ N	❑ Y ❑ N	❑ Y ❑ N

7 AUTHORIZATION

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.

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.

NOTICE OF ENROLLMENT RIGHTS

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.

Health insurance or medical services benefits provided or administered by The United HealthCare Insurance Company, Hartford, CT.

X **Signature**_____ **Date**_____

8 TO BE COMPLETED BY EMPLOYER

DATE OF HIRE	DATE SUBMITTED	EFFECTIVE DATE	POLICY NUMBER	Division	REPORTING CODE/BRANCH	EMPLOYER SIGNATURE