

HEALTH INSURANCE ENROLLMENT OR WAIVER

Instructions. Complete Section I if you wish to enroll in medical and or dental insurance. Complete Section II if you wish to waive your medical insurance. Complete Section III if you have other coverage whether or not you waive our coverage.

Name		Marital Status <input type="checkbox"/> M <input type="checkbox"/> S		Date of Hire	Eff Date
Street Address		City		State	Zip
Qualifying Event <input type="checkbox"/> New Hire/Re Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Loss of coverage (Attach proof) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Divorce <input type="checkbox"/> Workers Comp <input type="checkbox"/> FMLA or Dis leave <input type="checkbox"/> Full/Part time stat chg <input type="checkbox"/> Dep loss of coverage <input type="checkbox"/> Death of member				Event Date	
Additions <input type="checkbox"/> New <input type="checkbox"/> Reinstatement <input type="checkbox"/> Add dependent(s)		Terminations <input type="checkbox"/> Remove subscriber <input type="checkbox"/> Remove dependent		Changes <input type="checkbox"/> Individual to Family <input type="checkbox"/> Family to Individual	

I. ENROLLMENT IN COVERAGE

Medical Insurance <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> None				Dental Insurance <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> None				
Name Last First		Birth Date	Sex M or F	Relationship	Social Security No	If Full Time Student Name of Coll.	Admiss Mo Yr	
<i>Employee</i>				<i>Self</i>				

II. WAIVER - Proof of other medical coverage required below.

Name of Policy Holder	Relationship	Policy Number	Group Number
Name of Other Insurance	Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family	Employer Name Coverage is Through	

III. OTHER INSURANCE INFORMATION

Medical		Dental	
Name of Policy Holder	Relationship	Name of Policy Holder	Relationship
Name of Other Insurance	Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family	Name of Other Insurance	Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family
Policy Number	Group Number	Policy Number	Group Number
Employer Name Coverage is Through		Employer Name Coverage is Through	
Is anyone in this application eligible for Medicare coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of eligible person	

Please Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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 30 days after the marriage, birth, adoption, or placement for adoption.

Employee Certification. I have read and understand the above notification. I understand that if I decline plan coverage, I will only be able to obtain such coverage upon the plan's open enrollment period or because of one or more of the events listed above. I certify that all information provided is true and correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer. I authorize deduction of required employee contributions pre-tax, from my wages periodically.

Employee Signature _____	Date _____	HR ADP _____ Only: Initials-Date	DD _____ Initials-Date	UHC _____ Initials-Date	CC _____ Initials-Date
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