

# CA Key Accounts Employee Enrollment Form

To speed the enrollment process, please be thorough and fill out all sections that apply.

Unimerica Insurance Company

|  |         |   |                  |   |
|--|---------|---|------------------|---|
| <b>To Be Completed by Employer</b>   |         | Requested Effective Date of Coverage/Date of Change / /   |                  |   |
| Position/Title   | Product | Group #   | Plan Variation # | Reporting Code  |
| Hours Worked per Week  | Medical |   |                  |   |
| Date of Hire   | Dental  |   |                  |   |
| Group Name   | Vision  |   |                  |   |
| DBA (if applicable)  | Life    |   |                  |   |
| <b>Reason for Application</b><br><input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire<br><input type="checkbox"/> Life Event/Date ___/___/___ <input type="checkbox"/> Annual Open Enrollment<br><input type="checkbox"/> Status Change _____<br><input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Late Enrollee<br><input type="checkbox"/> Change Name/Address <input type="checkbox"/> Rehire<br><input type="checkbox"/> Other _____ |         | <b>Employee Type (Check all that apply)</b><br><input type="checkbox"/> Active <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired<br><input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____<br><input type="checkbox"/> Early Retiree<br><input type="checkbox"/> COBRA <input type="checkbox"/> Cal COBRA<br>Start date ___/___/___    End date ___/___/___<br>Indicate Qualifying Event _____<br>Original Qualifying Event Date<br>Begin date ___/___/___    End date ___/___/___ |                  | <b>Cancellations: Last Date of Employment ___/___/___</b><br>Requested Effective Date of Cancellation ___/___/___<br><input type="checkbox"/> Cancel all coverage<br><input type="checkbox"/> Cancel all listed below – Section B (family information)<br><input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce<br><input type="checkbox"/> Moved out of service area<br><input type="checkbox"/> Dependent reached student/dependent max age<br><input type="checkbox"/> Other (describe) _____ |

|   |   |   |   |                        |   |
|---|---|---|---|------------------------|---|
| <b>A. Employee Information</b>  |   | Complete all sections   |   |                        |   |
| Last Name   |   | First Name  | MI  | Social Security Number | Home Phone<br>Work Phone  |
| Address   |   | Apt #   | City  | State                  | Zip Code<br>E-mail Address  |
| Date of Birth   | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce<br><input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner | Have you or your dependents ever been a UnitedHealthcare or PacifiCare member? <input type="checkbox"/> Yes <input type="checkbox"/> No |                        | Preferred Language:<br><input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese<br><input type="checkbox"/> Korean <input type="checkbox"/> Other _____ |
| Primary Care Physician <sup>(1)</sup> (First & Last Name)/ID#             |   |   | Primary Care Dentist <sup>(2)</sup> (First & Last Name)/ID#   |                        |   |
| Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   | Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No   |                        |   |

|   |                        |  |                                |            |   |  |   |
|---|------------------------|--|--------------------------------|------------|---|--|---|
| <b>B. Family Information</b>  |                        | Complete all sections for all family members.            |                                |            |   |  |   |
| Check Appropriate Box   | Name (Last, First, MI) | Sex  | Relationship <sup>(4)</sup>    | Birth Date | Full-Time Student <sup>(5)</sup>                            | Provide Primary Care Physician <sup>(1)</sup> and/or Dentist Name <sup>(2)</sup> and ID#   | Disabled <sup>(6)</sup>                                     |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Cancel<br><input type="checkbox"/> Change<br><input type="checkbox"/> Waiver  | Address <sup>(3)</sup> | <input type="checkbox"/> M<br><input type="checkbox"/> F | Spouse/<br>Domestic<br>Partner |            |   | Physician:<br>ID#:<br>Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Dentist:<br>ID#:<br>Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____ |                        |  |                                |            |   |  |   |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Cancel<br><input type="checkbox"/> Change<br><input type="checkbox"/> Waiver  | Name (Last, First, MI) | <input type="checkbox"/> M<br><input type="checkbox"/> F | Dependent                      |            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Physician:<br>ID#:<br>Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Dentist:<br>ID#:<br>Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____ |                        |  |                                |            |   |  |   |

IMPORTANT: (1) Please use the Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) Include address only if different from Employee. (4) For court-ordered dependent, legal documentation must be attached. (5) Please see your employer representative for more information about the qualifications for full-time student status. (6) If answered "Yes" for disabled, please attach medical certification of disability.

**B. Family Information (cont.)** Complete all sections for all family members. (Attach sheet if necessary)

|   |                        |   |  |            |                                  |  |  |
|---|------------------------|---|--|------------|----------------------------------|--|--|
| Check Appropriate Box<br><input type="checkbox"/> Enroll<br><input type="checkbox"/> Cancel<br><input type="checkbox"/> Change<br><input type="checkbox"/> Waiver   | Name (Last, First, MI) | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Relationship <sup>(4)</sup><br>Dependent | Birth Date | Full-Time Student <sup>(5)</sup> | Provide Primary Care Physician <sup>(1)</sup> and/or Dentist Name <sup>(2)</sup> and ID#   | Disabled <sup>(6)</sup><br><input type="checkbox"/> Yes<br><input type="checkbox"/> No |
|   | Address <sup>(3)</sup> |   |  |            |                                  | Physician ID#: Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Dentist ID#: Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____ |                        |   |  |            |                                  |  |  |

|   |                        |  |           |            |   |  |   |
|---|------------------------|--|-----------|------------|---|--|---|
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Cancel<br><input type="checkbox"/> Change<br><input type="checkbox"/> Waiver  | Name (Last, First, MI) | <input type="checkbox"/> M<br><input type="checkbox"/> F | Dependent | Birth Date | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Physician ID#: Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
|   | Address <sup>(3)</sup> |  |           |            |   | Dentist ID#: Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____ |                        |  |           |            |   |  |   |

**C. Product Selection** Please check all that apply. Benefit offerings are dependent upon employer selection.

| Person                  | Medical                  | Dental                              | Vision                   | Life                     | Other                    |
|-------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Employee                | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spouse/Domestic Partner | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dependents              | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Medical Plan – If your employer offers you a choice of medical plans (i.e., Choice Plus, HMO) please write your medical plan selection here \_\_\_\_\_  High  Low
- Dental Plan – If your employer offers you a choice of dental plans (i.e., DHMO, DPPO) please write your dental plan selection here DHMO

**D. Group Life Insurance** Complete only if your employer is offering this benefit through UnitedHealthcare

|   |  |                     |                    |
|---|--|---------------------|--------------------|
| Job Title   | Employee's Benefits – Life: \$   |                     |                    |
| Number of hours worked per week   | Salary/Wages Required only if Life Plan based on Salary<br><input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$ | Spouse – Amount: \$ | Child – Amount: \$ |
| As a covered employee, you have the right to select and/or change your beneficiary(ies) in accordance with the provisions of your policy. |  |                     |                    |
| Life Insurance Primary Beneficiary (full name and address)  | Percentage   | Relationship        |                    |
| Contingent Beneficiary (full name and address)  | Percentage   | Relationship        |                    |

**E. Prior Medical Insurance/Health Plan Coverage Information** This section must be completed to receive credit for prior medical insurance/health plan coverage.

Within the last 12 months, have you, your spouse/domestic partner, or your dependents had any other medical coverage?  
 NO  YES (If YES, please complete this section and attach proof of coverage)

Prior medical carrier name \_\_\_\_\_ Effective date \_\_\_/\_\_\_/\_\_\_ End date \_\_\_/\_\_\_/\_\_\_

Policy # (if applicable) \_\_\_\_\_

Prior coverage type:  Employee  Spouse/Domestic Partner  Child(ren)  Family

Have you met any of your calendar year deductible?  Yes  No (If Yes, attach most current Explanation of Benefits/Explanation of Payment from the previous insurance company/health care service plan.)

Detach here