Enrollment Application and Change Form

HEALTH RISK ASSESSMENT

Our health benefits program reflects our commitment to a healthy workforce. All employees and covered spouses who choose our health benefits plan, are offered the opportunity to complete a confidential Health Risk Assessment (HRA) questionnaire and a basic biometric screening.

If an employee and/or covered spouse choose not to participate in the HRA and biometric screening, they will be charged an additional $80.00 per month in healthcare premiums for both the employee and covered spouse in the plan for a maximum of $160 per month if neither choose to participate.

To schedule an HRA and Biometric Screening, call the Healthstat Scheduling Line at 1-866-959-9355 or 414-304-8787 during clinic hours. The Health & Wellness Clinic is open Tuesdays and Thursday, 7:00 a.m. - 6:00 p.m. and is located at 8640 S. Howell Avenue, in the 9th Grade Center at the Oak Creek High School.

This must be done within 30 days of enrollment or qualifying event.

INSTRUCTIONS

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 . . . . . .Complete all information.

SECTION 2 . . . . . .Check the coverage plan you would like (Be sure to check with your employer to see which plans are being offered).

SECTION 3 . . . . . .Select who should be covered on the plans.

SECTION 4 . . . . . .Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5 . . . . . .Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan
T = To terminate your or a dependent's coverage
C = To change information about yourself or a dependent

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked Other Insurance and complete Section 6. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is disabled or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6 . . . . . .This section must be completed for all new enrollments or coverage changes.

SECTION 7 . . . . . .The employee must sign and date this form in order for it to be processed.

SECTION 8 . . . . . .This section is to be completed by the employer's benefit representative.

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PLEASE READ INSTRUCTIONS ON REVERSE SIDE.

UnitedHealthcare®
A UnitedHealth Group Company

☐ **New Coverage** ☐ **Request for Change**

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	Work Phone Number
Oak Creek-Franklin Joint School District	( )

2 TYPE OF MEDICAL COVERAGE

☐ I decline coverage for myself
☐ I decline coverage for my dependents

Reason:

☐ covered under another plan
Other: _____
(see sections 6&7)

***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 a late enrollee if you enroll in this plan at a later date.**

3 WHO SHOULD BE COVERED

☐ Employee Only
☐ Employee & Family

4 TYPE OF CHANGE

☐ Add Spouse/Child (complete Sec. 5)
☐ Terminate Spouse/Child (complete Sec. 5)
☐ Address (enter above)
☐ Name Change (complete Sec. 5)
☐ Terminate All Coverage – Reason
_____

Reinstatement – Reason
_____
Surviving Spouse – Former Employee SSN
_____
COBRA Continuee – Former Employee SSN
_____
Other _____

5 COVERAGE INFORMATION

(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Social Security Number	Date of Birth (MM/DD/YY)	Sex	Other Insurance	Disabled	
	Employee								
	Spouse					☐ M ☐ F	☐ Y ☐ N		
	Child 1					☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
	Child 2					☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
	Child 3					☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	

6 OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another United HealthCare plan, Medicare or Medicaid? ..... ☐ Y ☐ N
Is another person legally responsible for coverage for your children? ..... ☐ Y ☐ N
If you answered yes to either of the 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 Number
Other Company's Policy Number and Effective Date		
Medicare Number	Part A Effective Date	Part B Effective Date

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 United HealthCare and its affiliates (and the employer) or any of their designees, 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 dependents' 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 employees 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 my 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 United HealthCare Insurance Company, Minneapolis, MN.

X Signature _____ Date _____

8 TO BE COMPLETED BY EMPLOYER

Date of Hire	Date Submitted	Health/Change Eff. Date	Policy Number	GRP/SUBGRP/BNFT GRP	Plan Variation/Sub	Reporting Code/Branch	Employer Signature