



## Employee **Form** Help Sheet

The Following Fields Are Mandatory For Installing a Group\*

Date of Hire	Complete Name	Social Security Number
Phone Numbers	Complete Address	Product Selection
Complete Family Information	Employee Date of Birth	COBRA/Continuation Dates
Medicare Information	Salary for Life Benefits	Annual Open Enrollment Date
Other Coverage Information		

\*If any of the above fields are missed, a delay in processing the group will occur

### **Date of Hire**

The first day of employment. This is a mandatory field and must be completed by employer.

### **Employee Information**

Social Security Number – This is needed for accurate claim payment. To protect privacy and Social Security Numbers, UnitedHealthcare will assign an Alternate Identification Number for all external correspondence.

### **Family Information**

Student Status – Check the “yes” or “no” box to indicate the full-time student status of each dependent child to be included for any coverage offered on this application.

### **Product Selection**

Indicate coverage types (Medical, Life, Dental, Vision, STD and LTD) elected for Employee, Spouse and Dependents by placing an “X” or writing “yes” in the appropriate boxes. Please verify which benefits are being offered. For Life benefit, provide the desired allowable benefit amount. The following benefits are currently not available to employees: Sup Life, Sup AD&D, STD and LTD.

### **Other Coverage Information**

Has anyone on this application been covered with health benefits, including coverage with UnitedHealthcare within the past 2 years? – check the appropriate box, “yes” or “no.” If “yes” include dates of coverage and all family members covered. This information is necessary for coordination of benefits and proper claim payment.

Are you or any of your dependents covered by Medicare? – To insure proper claim payment and coordination of benefits please indicate “yes” or “no.” If “yes,” check the appropriate reason: over 65, disabled, or kidney disease. Indicate if the Medicare coverage is Part “A,” “B” or both by checking the appropriate boxes. In the next line, provide the full name of the family member covered by Medicare, the date the Medicare coverage went into effect and the claim number.

### **Waiver of Coverage**

An employee must elect coverage in order for his/her dependents to be eligible for coverage. This section must be completed if any of the family members listed are waiving any of the coverages offered on this application. If any one dependent waives coverage, this will not effect the eligibility of the other dependents. If an employee does not have dependents, but is waiving all coverage, check “Myself and all dependents.”

Check the box that best represents the reason for waiving coverage for the employee and/or any dependents. If “other” is checked, it is necessary to provide the reason in the space provided.

### **Signature**

The form must be signed and dated by the employee even if the employee is waiving all coverage for himself/herself and his/her dependents.

### **Medical History**

The health questions pertain to the employee and any persons listed in the “Family Information” section of the application. Check “yes” if anyone has consulted with or been examined or treated by any health care professional during the last five years for any illness, injury, or health condition in any of the categories listed. It is important to provide full details regarding any “yes” answers as this will reduce the processing time of the application.