UNITEDhealthcare® of New Jersey, Inc.

HEALTH MAINTENANCE ORGANIZATION (HMO) ENROLLMENT APPLICATION AND CHANGE FORM.
SMALL EMPLOYER HEALTH BENEFITS PLAN FOR EMPLOYEES AND DEPENDENTS.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed below, I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by United HealthCare of New Jersey, Inc. after a review of the application (and receipt of payment).

2. Applicant is applying for coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full time students at an accredited educational institution and receive at least half of their support from applicant and/or applicant's spouse and neither applicant's spouse nor children are eligible for group health benefits coverage.

3. Coverage and benefits are contingent on timely payment and may be terminated as provided in the Contract.

4. The Contract will determine the rights and responsibilities of the member(s) and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

For Employer's Use Only

Company's Name: ____

Date of Hire _____/_____/_____ Group No. ______________ Effective Date ________________

________________________________ Benefits Administrator's Signature

________________ Date

REASON'S FOR APPLICATION (Please indicate why you are submitting this application.)

____ New Hire ____ Change (see 3 below) ____ COBRA ____ Open Enrollment ____ Other

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Please print in ink all information requested on this application.

1. Eligible Persons to be enrolled. Note: Dependent children may be covered under their parents contract only when unmarried and until they reach age 19 or 23, if full time students. Unmarried, mentally and physically handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.

This next section must be completed in its entirety.

Last Name	First Name	MI	Birthdate MO	DAY	YR	Sex M or F	Social Security Number
Applicant 1. ☐ Add ☐ Remove							
Spouse 2. ☐ Add ☐ Remove							
Child 3. ☐ Add ☐ Remove							
Child 4. ☐ Add ☐ Remove							
Child 5. ☐ Add ☐ Remove							

* Attach sheet to list additional children. Attach proof if full-time student. Attach proof of disability

Marital Status: ____ Single ____ Married ____ Divorced

Reasons for Enrollment (Please check appropriate response)

_____ I am an employee of an organization which is applying for coverage
_____ I am now eligible for coverage and:
_____ had no previous coverage during the past 90 days; or
_____ had previous coverage during the past 90 days
Name of previous carrier ______________________ Plan # ____________
_____ I previously refused/waived coverage.
_____ I am applying for coverage during my organization's HMO open enrollment period. Open enrollment date ____________
_____ I am continuing coverage under state or federal law.
_____ I am adding (deleting) dependent(s).
_____ other (specify) ______________________

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at a another address? _____ Yes _____ No
If yes, who and at what address? ______________________

____

Explain the circumstances ______________________

If any dependent's last name is different from yours, explain the circumstances ______________________

____

2. PRIMARY RESIDENCE

____

Street Apt. City State Zip County

TELEPHONE

Home ( ) Work ( ) Best place to call during the day _____ Home _____ Work

Are you a resident of the state of New Jersey? _____ Yes _____ No
Do you maintain a residency in any other state? _____ Yes _____ No
If "Yes," (a) Name of state ____________
(b) How much time do you spend there each year? ____________

3. COVERAGE (Please mark Coverage and Type of Activity)

_____ Single _____ Family _____ Parent and Child(ren) _____ Husband/Wife

Type of Activity:
_____ New Subscriber
_____ Add/Remove Dependent
Reason ____________
Date of Event ____________
_____ New Telephone Number
(h) ____________ (w) ____________
_____ Change Contract Type From/To ____________
_____ Name Change From/To ____________
_____ Change of (Primary or Gyn) (Health Center)
_____ Withdrawal From Coverage ____________
Date of Event ____________
_____ New Address

4. OTHER HEALTH CARE COVERAGE

Are you eligible for other health benefits coverage? Yes _____ No _____
(i.e., coverage under your employer's healthbenefits coverage, Medicare or Medicaid)

If yes, give name and policy no. of other carrier or type of coverage. ______________________

____

Are other family members eligible for coverage? If yes, specify ______________________

Are you replacing existing coverage? Yes _____ No _____

If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy.

____

5. PIP SELECTION

Which coverage have you selected to be primary in the event that expenses are incurred as a result of an automobile-related injury?
_____ Auto _____ Medical

6. TERMINATION (Check Reasons)

_____ Deceased _____ Transferred to Other Coverage _____ Dissatisfied with Benefits _____ Ineligible _____ Moved Out of Area
_____ Dissatisfied with Medical Care _____ Dissatisfied with Access

Other, please explain ____

Remarks ____

7. PCP SELECTION		Primary Care Physician**	Current Patient	United HealthCare ID number	**IMPORTANT:
Applicant	1.		☐Y ☐N		Please use the United HealthCare directory of providers to choose a Primary Care Physician (PCP) for yourself and each of your covered dependents.
Spouse	2.		☐Y ☐N		
Child	3.		☐Y ☐N		
Child	4.		☐Y ☐N		
Child	5.		☐Y ☐N		

8. AUTHORIZATION AND CERTIFICATION

I hereby apply to United HealthCare of New Jersey, Inc. for coverage for eligible dependents listed above and myself.

I understand that for 6 months following the effective date of this policy, benefits are not proved for health services received for: (a) conditions for which medical advice, diagnosis, care or treatment was received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would have caused a prudent person to seek medical advice, diagnosis, care or treatment, or (c) pregnancy existing on the effective date of the is coverage. (Note: This limitation applied only to a health benefits plan coverage five or fewer eligible employees, and may not apply if the eligible person transfers from another health benefits plan. This limitation also applies to late enrollees unless 10 or more late enrollees request enrollment during any 30 day period.)

No person, except an Officer of United HealthCare of New Jersey, Inc. has authority to: determine whether any certification shall be issued on the basis of this Enrollment Application and Change Form; waive or modify any of the provisions of the Enrollment Application and Change Form or any of the requirements of this form; to bind United HealthCare of New Jersey, Inc. by any statement or promise pertaining to any certificate signed or to be issued on the basis of this Enrollment Application and Change Forms; or accept an y information or representation not contained in the written Enrollment and Change Form.

I agree that: (a) any physician, hospital or other provider is authorized to provide to United HealthCare of New Jersey, Inc. information about any eligible person's history: and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to United HealthCare of New Jersey, Inc.

I state that: (a) I reside within United HealthCare of New Jersey, Inc. service area, (b) the information given on this application is complete to the best of my knowledge and belief, and (c) that United HealthCare of New Jersey, Inc. will rely on this application to determine eligibility. I understand that if I omit or falsify any statement on this application United HealthCare of New Jersey, Inc. can cancel my coverage as of the original effective date.

Note: Any person who knowingly files a statement of claim, application for insurance, Enrollment Application and Change Form, containing any false or misleading information may be subject to criminal and civil penalties.

Applicant's Signature ______________________ Date Signed ______________________

Note to all applicants: If we accept your application, a copy of the application will be sent to you. Attach the copy of your evidence of coverage. It becomes part of your evidence of coverage.