EMPLOYEE ENROLLMENT FORM

Group Name: _____

EMPLOYER INFORMATION (TO BE COMPLETED BY HR)		
Enrollment (check one): ❑ New Enrollment ❑ Change of Enrollment Status	Effective Date of Insurance/Change:	
Enrollment/Change Reason: ❑ New Employee ❑ Rehired Employee ❑ Open Enrollment ❑ Transfer from Other Plan ❑ Involuntary Loss of Other Coverage (Prior Coverage Certificate required) ❑ Marriage ❑ Divorce ❑ Adoption (Legal Documents May be Required) ❑ Dependent Change Date of Event:		
Date of Hire:	Date Employee Entered Eligible Class (if not date of hire):	Employee Class:
Employee Hours Worked Per Week:	Job Title:	

EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)			
Employee Name:	Phone:		
Mailing Address:	City:	State:	Zip:

Add	Drop	Relationship to Employee	Name (Last, First, MI)	Social Security Number (required)	Date of Birth	Gender	
						Male	Female
❑	❑	Self					
❑	❑	Spouse/Domestic Partner					
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						

Is any child, over the dependent age limit of 26, applying for coverage due to disability? ❑ No ❑ Yes If yes, see Human Resources for additional paperwork.

GROUP MEDICAL / RX - EMPLOYEE PLAN SELECTION					
UnitedHealthcare Insurance Company UnitedHealthcare of Washington, Inc.	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child(ren)	❑ Employee + Family	❑ Decline
	Product Selection – Choose one plan only:				
	❑ Premier 500 ❑ Premier 1000 ❑ Premier 1500 ❑ Premier 2000 ❑ Premier 3000	❑ Preferred 500 ❑ Preferred 1000 ❑ Preferred 2500 ❑ Preferred 3500 ❑ Preferred 5000	❑ Preferred 6000 ❑ HSA 2500 ❑ HSA 4500	❑ Advanced 500 ❑ Advanced 1000 ❑ Advanced 2000 ❑ Advanced 3000 ❑ Advanced 5000	❑ Nexus 500 ❑ Nexus 1000 ❑ Nexus 1500 ❑ Nexus 2000 ❑ Nexus 2500
ANCILLARY BENEFITS - EMPLOYEE PLAN SELECTION (If offered by employer, complete where applicable.)					
Group Dental – Standard Insurance	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child(ren)	❑ Employee + Family	❑ Decline
Group Vision – Standard Insurance	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child(ren)	❑ Employee + Family	❑ Decline

Beneficiary for Employee's Group Life/AD&D Insurance (benefit underwritten and administered by United Healthcare Insurance Company)

Beneficiary Name	Relationship	Address	Benefit %

I authorize AGC Health Benefit Trust and its contracted service providers [including UnitedHealthcare Insurance Company and UnitedHealthcare of Washington, Inc. and its affiliates (collectively, "UnitedHealthcare")] to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives, or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment, and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. Send the revocation of authorization to 5 Centerpointe Dr. Suite 600, Lake Oswego, OR 97035, ATTN: UHC of OR, Inc. plan representative. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 24 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response is accurate and truthful to the best of my knowledge. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the producer or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any producer or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non- renew your coverage or change your premium retroactively to the date your policy became effective. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Please maintain a copy of this authorization for your records.

Employee Signature Print Name: Date: