Enrollment/Change Form

Group Dental Insurance, Vision Care Insurance provided by:
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
2950 Express Drive South, Suite 240
Islandia, NY11749-1412

UnitedHealthcare®

NEW YORK STATE FRAUD WARNING NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:
Employer Authorization:	Date of Hire: _________	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: ________		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Birth
☐ Divorce	☐ Court Ordered Dependent	☐ Death	☐ Other:
☐ Adoption/Legal Custody	☐ Cobra/State Continuation	Start Date ___/___/___	End Date ___/___/___

EMPLOYEE INFORMATION

SS# ___________-________-_______________	Employer Assigned ID# ___________	Date of Birth: ____________________	
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:	Annual Salary: $
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner *		

Number of hours worked per week: ______________

Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

FAMILY INFORMATION

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name / MI / Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No

*Domestic Partner coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, financially dependent upon subscriber/covered person and incapable of earning a living because of mental illness, developmental disability, or mental retardation. If answered "Yes" for Incapacitated, please attach medical certification of disability.

BENEFIT ELECTIONS		
Person	Dental	Vision
Employee Spouse (or Domestic Partner) Dependent	☐ ☐ ☐	☐ ☐ ☐
	☐ Waive (if applicable)	☐ Waive (if applicable)

AUTHORIZATION AND ACKNOWLEDGEMENT	Form must be signed

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

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Employee Signature:	Date: