# Enrollment/Change Form

Group Accident Insurance provided by:

**UNITEDHEALTHCARE INSURANCE COMPANY**
**185 Asylum St.**
**Hartford, CT 06103-3408**

Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance provided by:

**UNIMERICA LIFE INSURANCE COMPANY OF CALIFORNIA**
**10701 West Research Drive**
**Milwaukee, WI 53226**

## 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 | ☐ Domestic Partnership* |
| | ☐ Divorce | ☐ Dissolution Domestic | ☐ Death | ☐ Birth |
| | ☐ Adoption/Legal Custody | ☐ Court Ordered Dependent | ☐ Cobra/State Continuation | |
| | ☐ Other: | | 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 *

Employment Status: I am Actively at Work and have worked at my usual/required place of business for the past 30 days? ☐Yes ☐No
I am scheduled to work _____ hours per week and have worked those hours for the past 30 days? ☐Yes ☐No

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

## BENEFIT ELECTIONS

| Person | Basic Life | Basic AD&D | Supplemental Life | Supplemental AD&D |
|---|---|---|---|---|
| Employee | ☐ $________ | ☐ $________ | ☐$_________ | ☐ $_________ |
| Spouse (or Dom.Part*) | ☐ $________ | | ☐$_________ | ☐ $_________ |
| Dependent | ☐ $________ | | ☐$_________ | ☐ $_________ |
| | ☐ Waive (if applicable) | ☐ Waive (if applicable) | ☐ Waive | ☐ Waive |
| | | | Have you used tobacco of any kind in the past 12 months? ☐Yes ☐No<br>Spouse? ☐Yes ☐No | |

| Person | STD | LTD | Life Insurance Beneficiary(ies) Full Name and Address | Relationship |
|---|---|---|---|---|
| Employee | ☐ ________ | ☐________ | | |
| | ☐ Buy-up | ☐ Buy-up | 1) ______________________________ ☐ Primary ☐ Secondary | |
| | ☐ Waive (if applicable) | ☐ Waive (if applicable) | 2)______________________________ ☐ Primary ☐ Secondary | |

| Person | Accident Insurance | |
|---|---|---|
| Employee | ☐ Base Benefit | ☐ Base + Enhanced |
| Spouse (or Dom.Part*) | ☐ | |
| Dependent | ☐ | Additional Benefits (if applicable) |
| | ☐ Waive (if applicable) | ☐ Additional AD&D<br>☐ Outpatient Medical Expense<br>☐ Catastrophic Injury |

| FAMILY INFORMATION | Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary) | | | | |
|---|---|---|---|---|---|
| Check Appropriate Box | First Name MI Last Name (if different)<br>Dependent Social Security Number or Assigned ID | Date of Birth | Sex | Relationship** | Incapacitated*** |
| ☐ Enroll<br>☐ Change<br>☐ Cancel | <br>SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | ____/____/______ | ☐ M<br>☐ F | ☐ Spouse<br>☐ Domestic Partner* | Not Applicable |
| ☐ Enroll<br>☐ Change<br>☐ Cancel | <br>SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | ____/____/______ | ☐ M<br>☐ F | Dependent | ☐Yes ☐No |
| ☐ Enroll<br>☐ Change<br>☐ Cancel | <br>SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | ____/____/______ | ☐ M<br>☐ F | Dependent | ☐Yes ☐No |
| ☐ Enroll<br>☐ Change<br>☐ Cancel | <br>SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | ____/____/______ | ☐ M<br>☐ F | Dependent | ☐Yes ☐No |
| ☐ Enroll<br>☐ Change<br>☐ Cancel | <br>SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | ____/____/______ | ☐ M<br>☐ F | Dependent | ☐Yes ☐No |

*A Domestic Partnership is established when both persons have filed a Declaration of Domestic Partnership with the State of California.

**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 is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

## 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.

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.

FRAUD WARNING NOTICE:
For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

| Employee/Enrollee Signature: | Date: _____/_____/________ |
|---|---|