



MEDICAL & DENTAL ENROLLMENT/CHANGE REQUEST FORM

TRAVEL HCP PLAN

****CHECK OFF YOUR PLAN ELECTION AND RATES FOR BOTH MEDICAL AND DENTAL OPTIONS****

***BOTH PLANS HAVE A \$100,000 PER MEMBER CALENDAR YEAR LIMIT**

PREMIER UHC*

\$35 Office Visit Copay

Coinsurance:

75% In-Network/50% Out-of-Network

Deductible:

\$2,000 Ind./\$4,000 Fam. (In-Network)

Prescription: \$15/\$35/\$60

Rates

- Single - \$56.00
- 2 Party - \$573.00
- Family - \$891.00

STANDARD UHC* (does not provide Out-of Network)

\$35 Office Visit Copay

Coinsurance:

70% In-Network

Deductible:

\$4,000 Ind./\$8,000 Fam. (In-Network)

Prescription: \$10/\$35/\$70

Rates

- Single - FREE
- 2 Party - \$446.00
- Family - \$719.00

PLATINUM DELTA DENTAL PLAN

Deductible: \$50/\$150

100% Preventive/80% Basic Services

Major Services: 50%

Calendar Year Max: \$1,000

Rates

- Employee - \$18.00
- Employee & Spouse - \$51.00
- Employee & Child(ren) - \$57.00
- Employee & Family - \$90.00

BASE DELTA DENTAL PLAN

Deductible: \$100/\$300

90% Preventive/60% Basic Services

Major Services: Not Covered

Calendar Year Max: \$1,000

Rates

- Employee - FREE
- Employee & Spouse - \$15.00
- Employee & Child(ren) - \$28.00
- Employee & Family - \$43.00

TYPE OF ACTIVITY

Enrollment Check all that apply	Change Check all that apply	Remove or Terminate Check all that apply	Continuation of Coverage, i.e., COBRA Contact employer for available options
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> New Enrollee <input type="checkbox"/> Rehire Effective Date ____/____/____ Date of Hire ____/____/____ Date of Rehire ____/____/____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental Date of Event ____/____/____ Reason _____ <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other Control Suffix/Acct Plan _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental Effective Date ____/____/____ Reason _____ <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal <input type="checkbox"/> Termination <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Medical <input type="checkbox"/> Dental Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other Explain: _____ Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____

1 - EMPLOYEE INFORMATION - PLEASE PRINT CLEARLY

Employee Last Name: _____ First Name: _____ M.I. _____ Social Security#: _____

Address: _____ Date of Birth: ____/____/____

City: _____ State: _____ Zip Code: _____



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TRAVEL HCP PLAN

Date of Hire: ____/____/____ Fulltime Part-time Gender: Male Female Marital Status: Single Married

2- ELIGIBLE DEPENDENTS - LIST SPOUSE FIRST (IF YOU NEED MORE SPACE, ATTACH A SEPARATE SHEET OF PAPER.)

First Name, Middle Initial	Last Name (If different than employee's)	Relationship To Employee (ex. Spouse)	Birth date	Sex	Social Security #	Fulltime student 19 or older? * Y or N

*Complete the following for each child, age 19 or older, who attends an accredited school fulltime.

School Name _____ Term Begins ____/____/____ Expected Graduation Date ____/____/____

School Name _____ Term Begins ____/____/____ Expected Graduation Date ____/____/____

3 - OTHER COVERAGE INFORMATION

Are you or any eligible family members currently covered by other group health and/or dental insurance? Yes No
 If you answered "Yes" above, place a check next to those covered by other insurance and complete the rest of the information requested in Section 3. Myself My spouse My dependent children

Name of Insurance Carrier: _____ Name of Group: _____

To whom is the other coverage issued? Myself My Spouse Other
 Spouse's Birth Date: ____/____/____

4 - EMPLOYEE ELECTION AND SIGNATURE - ALWAYS REQUIRED

I hereby **apply** for coverage for:
 (Check only those that apply.)
 Myself Myself and my dependents

I hereby **decline** coverage for:
 (Check only those that apply.)
 Myself My Dependents Myself and my dependents

I read and understand the back of this form and request the actions checked above. I authorize any physician, hospital, pharmacy, employer, insurer, or other party to allow UHC/Delta Dental or their representatives to view, or receive copies or details of any medical data they have about me or my dependents, including treatment for sexually transmitted disease, HIV-related testing and treatment, and drug, alcohol, and psychiatric treatment, as needed to determine our eligibility for benefits. I understand that this information cannot be disclosed without my authorization. A copy of this authorization is as valid as the original.

Employee's Signature _____ Date ____/____/____

IMPORTANT INFORMATION ABOUT THIS INSURANCE APPLICATION

PLEASE READ CAREFULLY. THIS INFORMATION REFERS TO THE "EMPLOYEE SIGNATURE" SECTION ON THIS FORM.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.
 I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.
 I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company (ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under and existing policy.
 I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organizations for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (w) have the right to ask for and to receive a copy of this authorization.
 I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.
 I (we) have not given the agent or any other persons any health information not included on the Request for coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

United Healthcare Medical Plans effective April 1, 2010

Plan Name	UHC Premier Plan	UHC Standard Plan
Lifetime Maximum	\$2,000,000	\$2,000,000
Calendar Year Maximum	\$100,000	\$100,000
In-Network	Single/Family	Single/Family
Office Co-pay (PCP/SPC)	\$35 Per Visit	\$35 Per Visit
	\$500/day to \$2,500	
Other Co-pays (IP/ER/UC)	max/\$150/\$100	subject to deductible
Deductible	\$2,000/4,000	\$4,000/\$8,000
Coinsurance	75%	70%
Out-of-Pocket	\$8,000/16,000	\$10,000/20,000
Pharmacy	\$15/35/60	\$10/35/70
Out of Network	Single/Family	Single/Family
Deductible	\$5,000/10,000	Not Covered
Coinsurance	50%	Not Covered
Out-of-Pocket	\$9,000/18,000	Not Covered
HCP Costs:		
Employee Only	\$56.00	FREE
2-Party	\$573.00	\$446.00
Family	\$891.00	\$719.00