

Enrollment Application and Change Form

Please Read Instructions Carefully

1 Employee Information						
Last Name	First Name	MI	Sex M F	Date of Birth	Social Security Number	
Home Address			City	State	Zip Code	Marital Status Married Single
Group Number 702888			Group Name Tulane University		Department/Location	Home Phone Number ()
						Work Phone Number ()

2 Type of Medical Coverage	3 Who Should Be Covered	4 Type of Coverage
<input type="checkbox"/> Choice Plus Plan 13 – Basic Option (Low) <input type="checkbox"/> Choice Plus Plan 9 – Basic Plus (Medium) <input type="checkbox"/> Choice Plus Plan 10 – Basic Choice (High) <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse/Domestic Partner <input type="checkbox"/> Employee Plus Child/Children <input type="checkbox"/> Employee Plus Family	<input type="checkbox"/> Add Spouse/Child (complete Section 5) <input type="checkbox"/> Reinstatement <input type="checkbox"/> Terminate Spouse/Child (complete Section 5) <input type="checkbox"/> COBRA Continuee <input type="checkbox"/> Address (complete Section 1) <input type="checkbox"/> Surviving Spouse: <input type="checkbox"/> Name Change (complete Section 1) Employee Name _____ <input type="checkbox"/> Terminate All Coverage SS# _____

5 Coverage Information								
(A)Add (T)Term (Ch)Chg	Last Name	First Name	MI	Date of Birth (MM/DD/YYYY)	Social Security Number	Sex (M/F)	Disabled? (Y/N)	Full Time Student age 21 and less than age 25 (Y/N)
	Employee							
	Spouse							
	Child 1							
	Child 2							
	Child 3							

Authorization

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purposes of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I understand that the premium for health coverage will be paid before taxes unless I elect otherwise. I agree that my regular pay will be reduced by the amount of the required contribution under the terms of the plan.

Health Insurance or medical services benefits provided or administered by United Healthcare Insurance Company, Minneapolis, MN.

Employee Signature: _____ **Date:** _____