

Enrollment Application/Change/Cancellation Request



Neighborhood Health Partnership

- Enroll
- Cancel
- Change
- Address Change
- Name Change
- Add/Remove

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name CITY OF MIAMI SPRINGS		Group #	Department #
Plan Variation Medical <input checked="" type="checkbox"/> Vision _____ Dental _____ Life _____		Reporting Code Medical _____ Vision _____ Dental _____ Life _____	Benefit Level/Class Code, if applicable Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____

Change Form Reason: _____
 Effective Date of Change/Add/Cancellation: _____

X A. Employee Information

Last Name		First Name		MI	Social Security Number		Home Phone	
							Work Phone	
Address			Apt #	City	State	Zip Code	Email Address	
Date of Birth / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Physician* (First & Last Name) / Physician's Zip Code					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Race – Check all that apply (Optional)** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify _____						

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) selection.
 **Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

X B. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.			
Employee	<u>Medical</u>	HMO-LOW (F0CM)	HMO-HIGH (F0BG)
Emp + Spouse	<input type="checkbox"/>	<input type="checkbox"/>	HMO-HIGH (F0BG) POLICE
Emp + Children	<input type="checkbox"/>	POS (F0DV)	CONTRACT
Emp + Family	<input type="checkbox"/>	<input type="checkbox"/>	CHOICE (0L1)

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.
 Dental coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.
 Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
 Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or the at toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

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 an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization 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 (we) have the right to ask for and to receive a copy of this authorization.

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.

X C. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken English Spanish Other

X D. Family Information List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name	First Name	MI	Sex	Relationship**	Birthdate	Full Time Student***	Physician*(First and Last Name) Physician's Zip Code
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Social Security Number			M	Spouse			
				F				
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change				M	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP & Zip Code
				F				
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Employee Name _____

SSN: _____

Please Print

- * IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.
- ** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.
- *** Please see employer representative for student status qualifications.
- **** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.