

high mid low PPD

Subscriber Last, First Name _____ SSN _____

B. Family Information (cont.)						Complete all sections for all family members. (Attach sheet if necessary)	
Check Appropriate Box ☐ Enroll ☐ Cancel ☐ Change	Name (Last, First, MI)		Sex ☐ M ☐ F	Relationship ⁽⁹⁾ Dependent	Birth Date ____/____/____	Used tobacco within the last 12 months? ☐ Yes ☐ No	
	Social Security Number						
	Address (if different from Employee)			Permanently Disabled and age 26 or older ⁽⁹⁾ ☐ Yes ☐ No			
	Primary Care Physician ⁽¹⁰⁾ Name: _____ Address _____ ID# _____ Existing Patient ☐ Yes ☐ No			Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other			
	Primary Care Physician ⁽¹⁰⁾ Name: _____ Address _____ ID# _____ Existing Patient ☐ Yes ☐ No			Primary Care Dentist ⁽¹⁰⁾ Name _____ ID# _____ Existing Patient ☐ Yes ☐ No			
Check Appropriate Box ☐ Enroll ☐ Cancel ☐ Change	Name (Last, First, MI)		Sex ☐ M ☐ F	Relationship ⁽⁹⁾ Dependent	Birth Date ____/____/____	Used tobacco within the last 12 months? ☐ Yes ☐ No	
	Social Security Number						
	Address (if different from Employee)			Permanently Disabled and age 26 or older ⁽⁹⁾ ☐ Yes ☐ No			
	Primary Care Physician ⁽¹⁰⁾ Name: _____ Address _____ ID# _____ Existing Patient ☐ Yes ☐ No			Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other			
	Primary Care Physician ⁽¹⁰⁾ Name: _____ Address _____ ID# _____ Existing Patient ☐ Yes ☐ No			Primary Care Dentist ⁽¹⁰⁾ Name _____ ID# _____ Existing Patient ☐ Yes ☐ No			
Check Appropriate Box ☐ Enroll ☐ Cancel ☐ Change	Name (Last, First, MI)		Sex ☐ M ☐ F	Relationship ⁽⁹⁾ Dependent	Birth Date ____/____/____	Used tobacco within the last 12 months? ☐ Yes ☐ No	
	Social Security Number						
	Address (if different from Employee)			Permanently Disabled and age 26 or older ⁽⁹⁾ ☐ Yes ☐ No			
	Primary Care Physician ⁽¹⁰⁾ Name: _____ Address _____ ID# _____ Existing Patient ☐ Yes ☐ No			Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other			
	Primary Care Physician ⁽¹⁰⁾ Name: _____ Address _____ ID# _____ Existing Patient ☐ Yes ☐ No			Primary Care Dentist ⁽¹⁰⁾ Name _____ ID# _____ Existing Patient ☐ Yes ☐ No			

Subscriber Last, First Name _____

SSN _____

G. Authorization to Release Medical Information and Signature

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. 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. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Please maintain a copy of this authorization for your records.

Employee Signature	Employee Name (please print)	Date
		____/____/____