Level Funded plan participant enrollment application form

UnitedHealthcare Level Funded

Send correspondence to: P.O. Box 31394, Salt Lake City, UT 84131 • Phone: 1-877-797-8812

Fill out the entire enrollment application form to avoid processing delay. Please clearly print all information.

Enrollee Social Security Number | | | | – | | | – | | | | |

Group No. | | | | | | | | |

Enrollee Information

Plan Sponsor Name

Plan Sponsor Address (If more than one location)

Last Name

First Name

Initial

☐ Single
☐ Married

Address

Apt #

City

State

ZIP

County

Phone #

Email Address

Cell Phone #

Occupation

Date Employed Full Time

Average Hours Worked Per Week

Are you an independent contractor? ☐ Yes ☐ No

continued

United Healthcare

Waiver (please complete if you are waiving medical coverage)

I waive medical coverage for: ☐ Self (and dependents) ☐ Spouse ☐ Dependent Children

Please state reason for waiving coverage: _____

Qualifying Coverage: _____ Other: _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X _____ Date _____

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION – The results of any genetic test, including genetic test information, shall not be used as the basis to: (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.

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