UnitedHealthcare®

ENROLLMENT FORM - Group Life and Disability

Group Life and Disability Insurance products provided by Unimerica Insurance Company, Unimerica Life Insurance Company, or UnitedHealthcare Insurance Company

Use this form to apply for or to make changes to the applicable coverages listed below.
Late applicants are subject to Evidence of Insurability.

The following information is required to accurately enroll you and your dependents in the applicable coverage(s) requested. Missing information will delay enrollment processing.

Name
Address, including zip code
Social Security Number
Gender
Date of birth
Hire date (not needed if initial new case enrollment)
Class (if applicable)
Subgroup (if applicable)
Annual salary (required for salary based benefits)
Tobacco use (if benefits/rates are based on non-tobacco, tobacco use)

<u>Supplemental Benefits:</u>
Amount of current coverage
Amount of new coverage requested
Total amount of coverage after adding current and new coverage amounts

<u>Dependent Benefits:</u>
Dependent name and relationship to Employee
Dependent date of birth
Gender
Handicapped information (if applicable)
Student information (full-time, part-time, date or enrollment and name of each school)

A. EMPLOYEE INFORMATION

☐ Enroll ☐ Cancel ☐ Address Change ☐ Name Change ☐ Other Date

Last Name First Name M.I.	Social Security Number	Gender ☐ M ☐ F	Date of Birth
Street Address Apt No. City State Zip Code			☐ Single ☐ Married
Home Phone ( )	Work Phone ( )	Annual Salary	
Employer or Group Name Division/Location Subgroup Code		Job Title	

If applicable, have you or your dependent(s) used tobacco of any kind during the last twelve months? ☐ Yes ☐ No
If Yes, who? ☐ Employee ☐ Dependent Spouse ☐ Dependent Child

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B. PRODUCT SELECTION – Application for (check all that apply):

Employee Hire Date: _____

Basic Life and AD&D Insurance:

☐ Basic Life Insurance ☐ Basic Accidental Death and Dismemberment (AD&D)

Employee Supplemental Life and AD&D Insurance: **Increases may be subject to Evidence of Insurability**

☐ Employee Supplemental Life:

Current Amount of Coverage: $_____

☐ Increase coverage by: $_____

☐ Decrease coverage by: $_____

Total Amount of Coverage: $_____

☐ Employee Supplemental AD&D:

Current Amount of Coverage: $_____

☐ Increase coverage by: $_____

☐ Decrease coverage by: $_____

Total Amount of Coverage: $_____

Beneficiary Designation: Beneficiary information should be maintained by the Employer on a separate Beneficiary form.

Basic Dependent Life and AD&D Insurance:

☐ Basic Dependent Life Spouse: $ _____ amount

☐ Basic Dependent Life Child(ren): $_____ amount

☐ Basic Dependent AD&D Spouse: $ _____ amount

☐ Basic Dependent AD&D Child(ren): $ _____ amount

Dependent Supplemental Life and AD&D Insurance: **Increases may be subject to Evidence of Insurability**

☐ Dependent Spouse Supplemental Life:

Current Amount of Coverage: $_____

☐ Increase coverage by: $_____

☐ Decrease coverage by: $_____

Total Amount of Coverage: $_____

☐ Dependent Spouse AD&D:

Current Amount of Coverage: $_____

☐ Increase coverage by: $_____

☐ Decrease coverage by: $_____

Total Amount of Coverage: $_____

☐ Dependent Child Supplemental Life:

Current Amount of Coverage: $_____

☐ Increase coverage by: $_____

☐ Decrease coverage by: $_____

Total Amount of Coverage: $_____

☐ Dependent Child AD&D:

Current Amount of Coverage: $_____

☐ Increase coverage by: $_____

☐ Decrease coverage by: $_____

Total Amount of Coverage: $_____

Disability Insurance:

☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

C. INFORMATION FOR DEPENDENT COVERAGE (List all family members to be covered)

Last name First Name M.I.	Date of Birth	Relationship	If child is over age 19, please indicate status and/or school	Gender	Check one
			☐ Handicapped ☐ Student at	☐ M ☐ F	☐ Enroll ☐ Waive ☐ Cancel ☐ Change
			☐ Handicapped ☐ Student at	☐ M ☐ F	☐ Enroll ☐ Waive ☐ Cancel ☐ Change
			☐ Handicapped ☐ Student at	☐ M ☐ F	☐ Enroll ☐ Waive ☐ Cancel ☐ Change
			☐ Handicapped ☐ Student at	☐ M ☐ F	☐ Enroll ☐ Waive ☐ Cancel ☐ Change

D. SIGNATURE (This form must be signed)

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

X _____ _____

Signature of Employee Date

E. EMPLOYER USE ONLY

☐ Initial enrollment following Date of Hire ☐ Late Applicant	Employee Effective Date (mm/dd/yyyy)	Signed for Employer by	Group Number