FOR OFFICE USE ONLY
Date of Hire:___________________________Effective Date:_________________________Date Submitted:_________________________

Upon completion of form turn into Finance (City Hall, Room 208)

City of Kenosha: Health Enrollment Application/Change Form

EMPLOYEE INFORMATION: ◯ NEW COVERAGE ◯ REQUEST FOR CHANGE ◯ TERMINATION OF COVERAGE ◯ DECLINE MEDICAL COVERAGE

Last Name, First Name, Middle Initial	Social Security #	Date of Birth	Sex
Home Address	**City, State, Zip Code**	**Home Phone #**	**Work Phone #**

◯ Single ◯ Full-Time ◯ Active ◯ Hire Date: ________________
◯ Married ◯ Part-Time ◯ Retired ◯ Department:________________

◯ Employee Only ◯ Employee + Spouse ◯ Employee + Child(ren) ◯ Employee + Family
◯ Decline Medical Only (Self) ◯ Decline Medical (Dependents)

COVERAGE INFORMATION (of Dependents):

Add (A) Term (T)	Last Name, First Name, Middle Initial	Relationship	Social Security #	Date of Birth	Sex	Disabled	Full-Time Student 19+?	Medical
						No Yes	No Yes	No Yes
						No Yes	No Yes	No Yes
						No Yes	No Yes	No Yes
						No Yes	No Yes	No Yes

AUTHORIZATION:

On behalf of myself and anyone enrolled on or added to this form (“Us”), I authorize any healthcare professional or entity to give UnitedHealthcare and it’s 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 purpose of identification. I understand and agree that an 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 this insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium and has been paid. By signing this form, I hereby certified that all information provided is true and correct. If my employees plans is a contributory plan, I direct my employer to deduct the amount of my required contribution from my pay. I can cancel this direction in writing at any time. I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, I must have a Qualifying Event. 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 a Qualifying Event such as other coverage ends. In addition, if a new dependent relationship forms as a result or 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 event.

Signature: ___________________________Date: ________

OTHER INSURANCE COVERAGE INFORMATION:

Person’s Name with Other Health Plan:	Social Security Number:	Date of Birth:	Medicare Number:
Other Insurance/Phone #:	Policy #/Effective Date:	Sex:	Part A OR Part B Effective Date: