# Health and Dental Enrollment Application and Change Form

City of Kenosha

PLEASE READ INSTRUCTIONS ON REVERS SIDE FIRST. FORWARD COMPLETED APPLICATION TO THE FINANCE DEPARTMENT.

☐ New Coverage ☐ Request for Change

## 1 EMPLOYEE INFORMATION

| Last Name | First Name | MI | Sex ☐ Male ☐ Female | Date of Birth | Social Security Number | Marital Status ☐ Single ☐ Married |
|---|---|---|---|---|---|---|
| | | | | | | |

| Home Address | City | State | Zip Code | Home Phone Number ( ) |
|---|---|---|---|---|
| | | | | |

| Division/Location | ☐ FT ☐ PT | ☐ Union _____ ☐ Non Union | ☐ Hourly ☐ Salary | ☐ Active ☐ Retired (Date ) | Work Phone Number ( ) |
|---|---|---|---|---|---|
| | | | | | |

## 2 WHO SHOULD BE COVERED

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus One Dependentt
- ☐ Employee Plus Child(ren)
- ☐ Employee Plus Family

## 3 WAIVER OF COVERAGE

- ☐ I decline coverage for myself - Medical / Dental
- ☐ I decline coverage for my dependents - Medical / Dental

*Reason:* ☐ covered under another plan (see sections 6&7)

☐ Other: _____

## 4 TYPE OF CHANGE

- ☐ Add Spouse/Child (complete Sec 5.)
- ☐ Terminate Spouse/Child (complete Sec 5.)
- ☐ Address (enter above)
- ☐ Name Change (complete Sec 5.)
- ☐ Terminate All Coverage - Reason

- ☐ Reinstatement- Reason
- ☐ Surviving Spouse - Former Employee SSN
- ☐ COBRA Continues - Former Employee SSN
- ☐ Other

## 5 COVERAGE INFORMATION

| (A) Add (T) Term (C) Chg | Last Name | First Name | MI | Social Security Number | Date of Birth (MM/DD/YY) | Sex | Other Insurance | Disabled | Full-Time Student Over 19? | Medical Coverage | Dental Coverage |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Employee | | | | | | ☐ Y ☐ N | | | ☐ Y ☐ N | ☐ Y ☐ N |
| | Spouse | | | | | ☐ M ☐ F | ☐ Y ☐ N | | | ☐ Y ☐ N | ☐ Y ☐ N |
| | Child 1 | | | | | ☐ M ☐ F | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | Child 2 | | | | | ☐ M ☐ F | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | Child 3 | | | | | ☐ M ☐ F | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |

## 6 OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another UnitedHealthCare plan, Medicare or Medicaid?..... ☐ Y ☐ N

Is another person legally responsible for coverage for your children?..... ☐ Y ☐ N

If you answered yes to either of the questions above, please complete the following:

| Person's Name with Other Health Plan | | Social Security Number |
|---|---|---|
| Date of Birth | Sex | Other Company's Name and Phone Number |
| Other Company's Policy Number and Effective Date: | | |
| Medicare Number | Part A Effective | Part B Effective |

## 7 AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give UnitedHealthcare and its 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 any 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 the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employees plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.

NOTICE OF ENROLLMENT RIGHTS

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 of 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 marriage, birth, adoption, or placement for adoption.

X Signature _____ Date _____

## 8 TO BE COMPLETED BY EMPLOYER

| Date of Hire | Date Submitted | Health Change Eff. Date | Summary Plan Description Supplied to Employee Initial Date |
|---|---|---|---|
| | | | |

# City of Kenosha

# Health and Dental Enrollment Application and Change Form

## Health and Dental Enrollment Application and Change Form

The City of Kenosha does have Open Enrollment. If you do not take the City health or dental plan at the initial time of offering for you and/or eligible dependents, you must have a qualifying event such as but not limited to: Legal Marital Status Change, Birth, Adoption, etc.... Be sure to always *refer to your Summary Plan Description on the City of Kenosha's intranet or on your myuhc.com web portal for more qualifying events.* ***A completed Enrollment Application form must be received 31 days from the qualifying event to be eligible for coverage.***

I have read and understand the above _____ (employee initials) _____ Date

INSTRUCTIONS

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 .....Complete all information.

SECTION 2 .....Select who should be covered on the plans.

SECTION 3 .....Complete this section if you choose to decline coverage for yourself or any of your dependents.

SECTION 4 .....Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5 .....Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan
T = To terminate your or a dependent's coverage
C = To change information about yourself or a dependent

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked Other Insurance and complete Section 6. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is disabled or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.) *MEDICAL AND DENTAL BOXES MUST BE COMPLETED FOR EACH PERSON LISTED.*

SECTION 6 .....This section must be completed for all new enrollments or coverage changes.

SECTION 7 .....The employee must sign and date this form in order for it to be processed.

SECTION 8 .....This section is to be completed by the employer's benefit representative.

**FORWARD COMPLETED APPLICATION TO THE FINANCE DEPARTMENT**