UnitedHealthcare

Enrollment/Change Form

Instructions

Section 1: Personal Information
Please complete information requested.

Section 2: Selected Coverage

- Select only one of the plans offered by your Employer for you and your family. All family members must be enrolled in the same plan.
- Select the individual(s) to be covered under the plan you have selected.

Section 3: Employee & Dependent Information

- List yourself and family members to be covered. You may attach additional sheets if necessary.
- Social Security Number is a required field for you and each of your family members.
- Select a Primary Care Physician (PCP) from the *Provider Directory* for you and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member in your family within your selected plan.

  PCP selection is only required if a SignatureValue™ HMO, SignatureValue™ Advantage HMO, SignatureValue™ Alliance HMO, SignatureValue™ Flex HMO, SignatureValue™ Focus HMO, SignatureValue™ Harmony HMO plan is selected. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.
- Verify that domestic partner coverage is available through your Employer.
- Unmarried enrolled Dependents require proof of dependency and incapacity status within 60 days of receipt of notice and prior to the Dependent reaching the Limiting Age.

Section 4: Benefit Coordination/Other Insurance Carrier Information
Please complete information requested, if applicable.

Employee Signature

You can either:
Accept the healthcare services coverage provided through your Employer by signing the space provided on the enrollment form. Your signature indicates that you have read, understand and agree to the terms and conditions below. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

OR

You can waive the health care services coverage provided through your Employer for yourself, your spouse, domestic partner or your Dependents by signing the DECLINATION OF COVERAGE FORM. We strongly recommend that you read through the entire form carefully before signing your name in ink and dating it. Please request the Declination of Coverage Form from your Employer.

Terms and Conditions – Please read carefully before signing

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in UnitedHealthcare's Group Health Plan offered through my Employer, and agree to and understand the following:

1. To be bound by the UnitedHealthcare Medical and Hospital Group Subscriber Agreement ("Agreement") if I have chosen the SignatureValue™ HMO, SignatureValue™ Advantage HMO, SignatureValue™ Alliance HMO, SignatureValue™ Flex HMO, SignatureValue™ Focus HMO, SignatureValue™ Harmony HMO.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. UnitedHealthcare or a designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from substance use disorder treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment, or health care operations of the Agreement.

4. Any intentional misrepresentation of a material fact in answering the questions on this application may result in the denial of benefits and the termination of my and/or my Dependents' membership with UnitedHealthcare.
5. Coverage shall not begin until acceptance of this enrollment by UnitedHealthcare. Upon acceptance of this application, UnitedHealthcare shall be bound by the terms of the Agreement, and any Amendments thereto.
6. I have received, read and understand the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form, Directory of Participating Medical Groups and a copy of this Enrollment Form.
7. My Dependents and I must reside in California, live or work in UnitedHealthcare of California's service area.
8. If my Dependents or I elect SignatureValue™ HMO, SignatureValue™ Advantage HMO, SignatureValue™ Alliance HMO, SignatureValue™ Flex HMO, SignatureValue™ Focus HMO, SignatureValue™ Harmony HMO, we will select a Primary Care Physician within a 30-mile radius of our Primary Residence or Primary Workplace.

SignatureValue™ HMO,
SignatureValue™ Harmony HMO

P.O. Box 30981
Salt Lake City, UT 84130
1-800-624-8822
711 (TTY)
1-866-372-1316 (Fax)

Visit our website @ www.myuhc.com

PLEASE SELECT:

□ NEW ENROLLMENT

□ CHANGE TO CURRENT ENROLLMENT

- o Name change
- o Address change
- o Dependent change

1. Personal Information (Please print on all sections of form)

Company Name SMART-MTA TRUST FUND			Date of Hire	
Last Name	First Name	M.I.	Suffix	□ Male □ Female
Residence Mailing Address				
City		State	ZIP	
Home Telephone	Work Telephone	Date of Birth (mm-dd-yy)		
Social Security #		Marital Status □ Married □ Widow □ Single □ Divorced □ Domestic Partner		
Are you currently on COBRA? □ Yes □ No Yes, qualifying event:		COBRA Qualifying Event Effective Date		
Preferred Language (optional) □ English □ Spanish				
Ethnicity (optional) □ Caucasian	□ Black or African American □ Asian, Native Hawaiian, other Pacific Islander □ American Indian or Alaskan Native	□ Hispanic or Latino □ Not provided by member		

Employer Required to Complete This Section	
Group #/Plan Code	
Source of Enrollment or Change:	
Open Enrollment	QMCSO
New Hire	Employee Status Change
Rehire	Life Event
Requested Effective Date	
Employer Verification/Signature	
Employee Class (Full Time or Part Time)	

2. Selected Coverage (Select only one of the plans offered by your Employer)

Medical Plan Options:

□ SignatureValue™ HMO □ SignatureValue™ Harmony HMO

3. Employee and Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self	Primary Care Physician (PCP) Name		Provider #		Existing Patient? Yes No
Spouse/ Domestic Partner*	Male Female	Last Name	First Name	M.I.	
Date of Birth (mm-dd-yy)	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name			Provider #		Existing Patient? ϒ Yes ϒ No
Dependent 1	ϒ Male ϒ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name			Provider #		Existing Patient? ϒ Yes ϒ No
Dependent 2	ϒ Male ϒ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name			Provider #		Existing Patient? ϒ Yes ϒ No
Dependent 3	ϒ Male ϒ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name			Provider #		Existing Patient? ϒ Yes ϒ No
Dependent 4	ϒ Male ϒ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name			Provider #		Existing Patient? ϒ Yes ϒ No

4. Benefit Coordination/Other Insurance Carrier Information

Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section boxes a–e

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address

Is anyone listed eligible for Medicare? ☐ Yes ☐ No If yes, complete section boxes f–g

f. Name	g. Medicare ID#

5. Signature Required on Terms and Conditions – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED ABOVE AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.

Signature (Required)	Date (Required)
X	

6. Signature Required on Binding Arbitration – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. A reproduction of this authorization shall be as valid as the original.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature (Required)	Date (Required)
X	

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.