(DO NOT STAPLE)

California
Small Business
Employee Enrollment Form

To speed the enrollment process, please be thorough and fill out all sections that apply.

United Healthcare

UnitedHealthcare Insurance Company
UnitedHealthcare of California
UnitedHealthcare Benefits Plan of California

To Be Completed by Employer	Group Name/Number	
Requested Effective Date of Insurance/Health Plan Coverage/ Date of Change / /	Reason for Application ☐ New Group Plan ☐ New Hire ☐ Dependent Add/Delete ☐ Annual Open Enrollment ☐ Change Name/Address ☐ Late Enrollee ☐ Termination Date: __/__/__ ☐ Waiving Coverage (Complete Sections A and E) ☐ Life Event/Date_____ ☐ Status Change _____ ☐ Other _____	Employee Type (check all that apply) ☐ Active ☐ Union ☐ Non-Union ☐ Retired ☐ Hourly ☐ Salary ☐ Other ☐ COBRA ☐ Cal-COBRA Start Date __/__/__ End Date __/__/__ Indicate Qualifying Event _____ Original Qualifying Event Date Start Date __/__/__ End Date __/__/__
Date of Hire / /		
Position/Title		
Hours Worked Per Week		

A. Employee Information	**Complete All Sections** **If you are waiving coverage, please complete only Sections A and E**

Last Name	First Name	MI	Social Security Number	Home Phone
Address	Apt # / City	State	ZIP Code	Cell Phone / Work Phone

Date of Birth / /	Sex ☐ M ☐ F ☐ U	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner	Have you or your dependents ever been a UnitedHealthcare member? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other _____

Race/Ethnicity – Check all that apply[1] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify — ZIP Code

E-mail address — To select paperless delivery complete and sign the enrollment form and provide your email address. Check here to receive your Required Plan Communications by mail ☐

Primary Care Physician[2] Name: _____
Address: _____
ID# Existing Patient Medical ☐ Yes ☐ No

Primary Care Dentist[3] Name: _____
ID#: _____
Existing Patient Dental ☐ Yes ☐ No

Coverage provided by "UnitedHealthcare and Affiliates":
Check appropriate box(s) for coverage(s) selected:
Medical ☐ UnitedHealthcare Insurance Company or ☐ UnitedHealthcare Benefits Plan of California (Insurance Products: Navigate, Select Plus, Core, Doctors Plan, Non-Diff)
Medical ☐ UnitedHealthcare of California (HMO)
Dental ☐ UnitedHealthcare Benefits Plan of California or ☐ UnitedHealthcare Insurance Company or ☐ Dental Benefit Providers of California, Inc.
Vision ☐ UnitedHealthcare Benefits Plan of California or ☐ UnitedHealthcare Insurance Company
Administrative services provided by United Healthcare Services, Inc. Optum Rx Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

IMPORTANT: (1) Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination. (2) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (3) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (4) For court-ordered dependent, legal documentation must be attached. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.