Employee Enrollment Form (Please Print)

California

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

Company Name			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 If 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: ☐ Open Enrollment ☐ QMCSO ☐ New Hire ☐ Employee Status Change ☐ Rehire
Requested Effective Date
Employer Verification/Signature
Employee Class

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

Medical Plan Options:

☐ UnitedHealthcare SignatureValue™ (HMO) ☐ High ☐ Low
☐ UnitedHealthcare SignatureValue™ Advantage (HMO)
☐ UnitedHealthcare SignatureValue™ Alliance (HMO)
☐ UnitedHealthcare SignatureValue™ Flex (HMO) Network 1
☐ UnitedHealthcare SignatureValue™ Flex (HMO) Network 2
☐ UnitedHealthcare SignatureValue™ Flex (HMO) Network 3
☐ UnitedHealthcare SignatureValue™ Focus (HMO)

Individual(s) to be covered:

☐ Self
☐ Self + Spouse
☐ Self + Dependent(s)
☐ Self + Family
☐ Waive Medical (Complete Waiver Form)

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? ☐ Yes ☐ No
Dependent 1	☐ Male ☐ 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? ☐ Yes ☐ No
Dependent 2	☐ Male ☐ 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? ☐ Yes ☐ No
Dependent 3	☐ Male ☐ 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? ☐ Yes ☐ No
Dependent 4	☐ Male ☐ 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? ☐ Yes ☐ 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.