☐ NEW COVERAGE
☐ REQUEST FOR CHANGE

Enrollment Application and Change Form

PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY.

UnitedHealthcare®

1 EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SEX ☐ Male ☐ Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER	EMPLOYEE ID #

HOME ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE NUMBER
				( )

EMPLOYER NAME	EMAIL ADDRESS:		MARITAL STATUS	WORK PHONE NUMBER
DADE COUNTY FIRE FIGHTERS INSURANCE TRUST		**ACTIVE**	☐ Single ☐ Married ☐ Widow	( )

2 TYPE OF COVERAGE

Medical
- ☐ **High Option**
- ☐ **Low Option**

Dental
- ☐ **DPPO**
- ☐ **DMO**

3 WHO SHOULD BE COVERED

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus Child/ren
- ☐ Employee Plus Family

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 Continuee Former Employee SSN _____
- ☐ Open Enrollment

5 * Dependent children covered up to end of month he/she turns 26

(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Social Security #	Date of Birth (Month/Day/Year)	Sex	Handicapped
	Spouse					☐ M ☐ F	☐ Y ☐ N
	Child-1*					☐ M ☐ F	☐ Y ☐ N
	Child-2*					☐ M ☐ F	☐ Y ☐ N
	Child-3*					☐ M ☐ F	☐ Y ☐ N
	Child-4*					☐ M ☐ F	☐ Y ☐ N
	Child-5*					☐ M ☐ F	☐ Y ☐ N

6 OTHER INSURANCE

On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, 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 Date	Part B Effective Date

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 The United HealthCare Insurance Company and its affiliates (and the employer) or any of their designees ("United HealthCare"), 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 dependent's 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 employer's 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, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or 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 such 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.

Health insurance or medical services benefits provided or administered by The United HealthCare Insurance Company, Hartford, CT.

X Signature _____ **Date** _____

8 TO BE COMPLETED BY EMPLOYER

DATE OF HIRE	HEALTH/CHANGE EFF. DATE	POLICY NUMBER	GRP/SUBGRP/BNFT GRP	PLAN VARIATION/SUB	REPORTING CODE/BRANCH	

Enrollment Application and Change Form
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 Check the coverage plan you would like (Choice Plus Plan Low Option (former HMO Plan) or High Option (former PPO Plan)

SECTION 3 Select who should be covered on the plan.(Copy of marriage and birth certificates must be provided for covered 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 yourself 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 COB (Coordination of Benefits) and complete Section 7. Provide Social Security Number, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is handipcapped or a full-time student. (If you have more than 5 dependents, please attach an additional enrollment form.)

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.

Change In Status/Mid-Year Plan Changes

How do I make a change to my health plan mid-year? Once the open enrollment period closes, you may add or delete dependents to your health plan only under limited circumstances (a qualifying event). Changes must be reported within 30 days of a qualifying event. You must provide proper documentation and complete a Miami-Dade Change in Status (CIS) form and a UHC Enrollee Change form to the Trust Office. Election changes must be consistent with the event and result in loss or gain of insurance coverage. Mid-year changes from one health plan to another are not permitted. A partial list of permitted mid-year changes appears below.

- Marriage\Divorce (Ex-spouse & step-children cease to be eligible as of the last day of month final divorce decree is signed by Judge
- Birth of a child
- Adoption of a child or placement for adoption
- Beginning or end of employment of a spouse (resulting in gain or loss of insurance coverage)
- Ineligibility of dependent child – (Eligibility for employer issued health coverage or active military dury)
- Employment change from full-time to part-time or vice versa (employee or spouse)
- Unpaid LOA (employee or spouse)
- Medicare/Medicaid/Florida Kid Care
- Spouse's employer open enrollment
- Significant change in health coverage due to spouse's employment.