



Mailing Address

[Grid for Mailing Address]

Apt or Suite

[Grid for Apt or Suite]

City

[Grid for City]

State

[Grid for State]

Zip

[Grid for Zip]

Work Phone Number

[Grid for Work Phone Number]

Home Phone Number

[Grid for Home Phone Number]

Cell Phone Number

[Grid for Cell Phone Number]

Date of Birth

[Grid for Date of Birth]

Gender

[Grid for Gender]

Social Security Number

[Grid for Social Security Number]

Marital Status:

[Grid for Marital Status]

Medicare Number (if applicable)

[Grid for Medicare Number]

Part A Effective Date

[Grid for Part A Effective Date]

Part B Effective Date

[Grid for Part B Effective Date]

If Medicare eligible due to ESRD please check type of dialysis:

[Grid for Dialysis Type]

**5 – Other Coverage Information**

Have you ever been a member of UniveraHealthcare?  Yes  No

**In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.**

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health?  No  Yes / Dental?  No  Yes

If answering "Yes", are you keeping the additional health and/or dental coverage? Health?  No  Yes / Dental?  No  Yes

Who did the other plan cover?  Self  Spouse  Children

Other insurance carrier name:

[Text box for Other insurance carrier name]

Other insurance name of policyholder:

[Text box for Other insurance name of policyholder]

Policy ID Number:

[Grid for Policy ID Number]

Effective Date

[Grid for Effective Date]

Termination Date

[Grid for Termination Date]

**6 – Cancellation Information**

**Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).**

Subscriber  Medical  Dental / Reason \_\_\_\_\_ Date [Grid]

Dependent (list each dependent in section 7)  Medical  Dental / Reason \_\_\_\_\_ Date [Grid]

**7 – Dependent Information**

**Please provide all information for each person to be covered.**

Subscriber's Last Name

[Grid for Subscriber's Last Name]

Subscriber's First Name

[Grid for Subscriber's First Name]

Spouse/Domestic Partner Last Name

[Grid for Spouse/Domestic Partner Last Name]

Spouse/Domestic Partner First Name

[Grid for Spouse/Domestic Partner First Name]

M.I.

Male

Date of Birth

[Grid for Date of Birth]

Social Security Number

[Grid for Social Security Number]

Are you enrolling as a Domestic Partner?

[Grid for Domestic Partner]

Female

Medicare Number (if applicable)

[Grid for Medicare Number]

Part A Effective Date

[Grid for Part A Effective Date]

Part B Effective Date

[Grid for Part B Effective Date]

Dependent's Last Name

[Grid for Dependent's Last Name]

Dependent's First Name

[Grid for Dependent's First Name]

M.I.

Male

Date of Birth

[Grid for Date of Birth]

Social Security Number

[Grid for Social Security Number]

Is your over-age dependent handicapped or disabled?

[Grid for Handicapped/Disabled]

Female

(See last page for additional information)  No

Is Dependent a full time student?  No  Yes If yes, please indicate college/university name:

College/University Name

[Text box for College/University Name]

Expected Graduation Date

[Grid for Expected Graduation Date]

Credit hours

[Grid for Credit hours]

**8 – Release/Signature**

**Subscriber signature required. You must sign and date this form to be eligible for insurance.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature \_\_\_\_\_

Date \_\_\_\_\_



## Instruction Page

**Reason for Enrollment/Change:** Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

### Cancel Request

To process a Subscriber or Dependent cancellation, please use the **Membership Cancellation Worksheet - OR -**

#### To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

#### Cancel Subscriber Reasons

Left Employer/No Longer Eligible	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

#### To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

#### Cancel Dependent Reasons

Marriage – when permitted by law	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	Medicare

**COVERAGE TYPE** All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

**SUBSCRIBER** If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

**FAMILY MEMBER INFORMATION** If there are more than seven dependents please use an additional form.

#### QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
  - Must be under the eligible child age for your employer group:
    - natural, adopted or stepchild
  - Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.
- Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.**

#### RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Univera Healthcare.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Univera Healthcare to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Univera Healthcare to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**  
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

**GROUP EMPLOYER INFORMATION** This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative

Or, visit us at: [www.univerahealthcare.com](http://www.univerahealthcare.com)