USF HEALTH MORSANI COLLEGE OF MEDICINE

INSURANCE ENROLLMENT VERIFICATION FORM

2019-2020

Residents are charged a premium **for dependent insurance coverage only**. The amount you are billed will depend on the level of dependent coverage that you elect. Once dependent coverage is elected, premium deductions are automatically deducted bi-weekly from your pay.

To ensure that we have the correct information on your dependent coverage, please complete the following information.

Resident Name: _____ Last 4 Digits of S.S.#_____
(Please print)

Please check as applicable:

Single Coverage (for myself only):	_____ YES	(No charge)
Dependent Coverage:		
Resident and Spouse* Only:	_____ YES	($50.00/month)
Resident and Family (Spouse* & Children)	_____ YES	($75.00/month)
Resident and Children Only	_____ YES	($75.00/month)

* If electing spouse coverage, a copy of your marriage certificate is required.

_____ I decline enrollment in USF resident health insurance and have attached proof that I am otherwise covered by another active policy.

_____ / /
Signature Date

Please be sure to complete the UCH enrollment form on the following pages.

SO ___
UHC ___

Enrollment Application/Change/Cancellation Request

UnitedHealthcare
A UnitedHealth Group Company

USF Health Morsani College of Medicine 2019-2020

☒ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name: USF Health Morsani College of Medicine | Group #: 701223 | Department #: GME Housestaff

Plan Variation
Medical X Vision ----
Dental ---- Life ----

Reporting Code
Medical X Vision ----
Dental ---- Life ----

Benefit Level/Class Code, if applicable
Life/AD&D ---- Suppl. Life ----
Spouse Life ---- Suppl. AD&D ----

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ Requested Date of Coverage ___ /___ /___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date_____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___ /__ /___

☐ **Cancellations:** Last Date of Employment ___ /___ /___
Requested Effective Date of Cancellation ___ /___ /___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
☐ Dependent reached maximum age
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☒ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

A. Employee Information

Employer Position_____ Phone Number_____

Last Name	First Name	MI	Social Security Number	Home Phone / Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth	Sex	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*
/ /	☐ M ☐ F	N/A -----	N/A

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Race – Check all that apply (Optional)** N/A
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**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.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical Entities should be as follows: UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Dental coverage provided by UnitedHealthcare Insurance or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name / First Name / MI / Social Security Number	Sex	Relationship**	Birthdate	Physician*(First and Last Name) / Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Spouse		N/A
Race – Check all that apply (Optional)*** N/A ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number* N/A
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** N/A ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number* N/A
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)* ** N/A ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number* N/A
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** N/A ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number* N/A
☐ Enroll ☐ Cancel ☐ Change	– –	M F	Dependent		
Race – Check all that apply (Optional)*** N/A ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number* N/A

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** 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.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐ N/A	☐ N/A	☐ $N/A	☐ N/A	☐ N/A	☐ N/A	☐	------
Spouse	☐	☐ N/A	☐ N/A	☐ N/A					
Dependents	☐	☐ N/A	☐ N/A	☐ N/A Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address — Relationship

PLEASE COMPLETE STANDARD INSURANCE BENEFICIARY FORM - DO NOT LIST HERE

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

N/A