

UnitedHealthcare Plan of the River Valley, Inc. (HMO)
 UnitedHealthcare Insurance Company of the River Valley (PPO)



APPLICATION/CHANGE FORM PERSONAL AND CONFIDENTIAL

Employer	Group No. & Billing Loc.	HMO <input type="checkbox"/> Select <input type="checkbox"/> Choice <input type="checkbox"/> Choice Standard <input type="checkbox"/> Select Advantage (Iowa only) <input type="checkbox"/> Premier	PPO <input type="checkbox"/>	Effective Date
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REQUESTED ACTION Sign and date in Section F.

ENROLLMENT APPLICATION
 COBRA APPLICATION
 CONVERSION APPLICATION
 CONTINUATION APPLICATION
 CHANGE NOTICE: (Check desired changes)
 Add
 Remove Dependent(s)
 (List dependent(s) to add or remove in Section B.)

Qualifying Event _____ **Effective Date** _____

Change Coverage to:
 Employee Only
 Employee/Spouse
 Employee/Child(ren)
 Family
 Cancel Coverage Effective: _____
 Change Name From: _____ (List New Name in Section A or B.)
 Change of Address - (List new address in Section A.)
 Other (Specify:)
 Change Coverage to Surviving Spouse:
 Name of Original Policyholder _____ Subscriber Number _____ Date of Death _____

A. SUBSCRIBER DATA

Social Security Number	Name (Last, First, MI)	Date of Birth (Month, Day, Year)	M/F
Address (Include Street, R.R., Apt. No.)		City	State Zip County Area Code and Phone Number
Primary Care Physician (PCP)		Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Surviving Spouse		Full-Time Hire Date	

Marital Status
 Single
 Married
 Divorced
 Widow/Widower
 Common Law Notarized Affidavit (Applies to Iowa only)

B. SPOUSE/DEPENDENT DATA: NEW APPLICATIONS - List persons to be covered. CHANGES - List persons to be added or removed.

Name (Last, First, MI)	Birth date (Month, Day, Year)	M/F	Relationship	Social Security Number	Primary Care Physician (PCP) Last Name, First Name
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

C. COORDINATION OF BENEFITS (Complete if any persons listed in Section B are covered by another insurance policy.)

Is your Spouse:
 Employed
 Retired
 Date of Marriage / /

Are any persons in Section A or B covered by another insurance policy?	If yes, list first names of all persons covered	If yes, give name of insurance company/HMO
<input type="checkbox"/> Yes <input type="checkbox"/> No		Member ID Number

D. MEDICARE DATA (Complete if any person(s) listed in Section A or B are covered by Medicare)

Name (Last, First, MI)	Medicare ID Number	Reason for Medicare (check one)			
		<input type="checkbox"/> Aged	<input type="checkbox"/> Disabled	<input type="checkbox"/> ESRD	<input type="checkbox"/> Hospice
		<input type="checkbox"/> Aged	<input type="checkbox"/> Disabled	<input type="checkbox"/> ESRD	<input type="checkbox"/> Hospice

E. PRIOR COVERAGE INFORMATION

Did you have health coverage within 63 days prior to the date on which you signed this application?
 Yes
 No
 If yes, please complete the remainder of this section.
 If Full-Time Hire Date stated in Section A is within the past six months, did you have health coverage within 63 days prior to that date?
 Yes
 No
 N/A
 If yes, complete the remainder of this section.

Name of Covered Person(s)	Employer (if applicable)	Insurance Company/HMO Name and Address
Policy No.	Contract Type <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	Effective Date End Date

F. REPRESENTATION (Please review the above application for completeness and read the following statement before signing below.)

I represent to the best of my knowledge and belief that all statements and answers made in this application are complete and true, and I understand that the answers to the above questions will be the basis of any coverage issued. UnitedHealthcare Plan of the River Valley, Inc. and UnitedHealthcare Insurance Company of the River Valley may obtain information relating to the occupation, mode of living, and avocations in order to evaluate this application.

I have read this authorization and I agree that, the length of time of this authorization will be (1) for the purpose of collecting information in connection with an application, 30 months (Iowa only- 24 months) or less from the date of signing; and, (2) for the purpose of collecting information in connection with a claim for benefits, the term of coverage. I understand that, upon request, I am, or my authorized representative or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I agree to abide by the provisions and regulations as set forth by the master contract applicable to the plan for which I have enrolled. Any material misrepresentation may result in re-rating of group premium, claim denial, and/or rescission of coverage. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company/HMO for the purpose of obtaining health coverage or health insurance. Penalties may include imprisonment, fines, and denial of benefits.

Employee/Subscriber Signature _____	Date _____	Employer Signature _____	Date _____
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