UnitedGroup PROGRAMS

4 TERRY DRIVE, SUITE 1
NEWTOWN, PA 18940
Phone: (800) 482-8770 Fax: (215) 968-6301
BILLING@UGPINC.COM

ENROLLMENT AND CHANGE FORM

Form 1B

Employer's Business Name:________________________________ ☐ **New Employee** ☐ **Change in Coverage**

Business Telephone Number:____________________ ☐ **Late Enrollee** ☐ **COBRA**

Business Address:____ City: ________ State: _____ Zip: ______

SECTION 1. ***Employee Information***

First	Middle	Last	Social Security Number	Marital Status
			- -	☐ Single ☐ Widowed ☐ Married ☐ Divorced

Home Address	City	State	Zip Code	Telephone Number
				( )

Date of Full-Time employment
Month Day Year

Annual Earnings
☐ Salaried ☐ Hourly

Beneficiary
Name: ___________________ Relationship: ______________________
Additional Information: (If needed): % __________

SECTION 2. COVERAGE	**Check Appropriate Box if 'YES' for Coverage and Offered by Employer**
Health Insurance	☐ Employee ☐ Spouse ☐ Child/Children ☐ Family
Dental Insurance	☐ Employee ☐ Spouse ☐ Child/Children ☐ Family
Life, AD&D Insurance	☐ Employee ☐ Spouse ☐ Child/Children ☐ Family
Disability Insurance	☐ Employee ☐ Spouse ☐ Child/Children ☐ Family
Vision	☐ Employee ☐ Spouse ☐ Child/Children ☐ Family

SECTION 3. PORTABILITY COVERAGE, PRE-EXISTING CONDITION EXCLUSIONS APPLY

Benefits may not be payable for pre-existing conditions (illnesses or injuries for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage). If a pre-existing condition applies, each participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan of coverage. Let us know if you need assistance in obtaining a certificate of prior coverage. Please review pre-existing condition limitations in your summary plan booklet. Failure to check a box below shall be deemed "no previous coverage".

- ☐ A HIPAA Certification Form(s) is attached.
- ☐ A HIPAA Certification Form(s) will be forwarded when received from prior benefit plans.
- ☐ I had no previous coverage, this provision does not apply to me, and I understand the pre-existing condition provision.

SECTION 4. ***Change in or Addition of Dependents Coverage***

☐ Marriage Date _____ ☐ Birth of first child/subsequent children Date _____ ☐ Other – give reason and date _____
☐ Divorce Date _____ ☐ Last dependent child reached limiting age Date _____

SECTION 5. ***Person Proposed for Coverage ****

	Name (First Middle Last)	**Social Security Number**	Sex	Age	Date of Birth Mo. Day Year
Employee		___ _			____________
Spouse					
Child					
Child					
Child					
Child					

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***If spouse has a <u>different last name</u>, attach a copy of your marriage license.**

If your child has a <u>different last name</u>, attach a copy of their Birth Certificate.

Do you, spouse, or children have other group *insurance coverage? Yes___ No___*

Are you or any member of your family, applying for coverage, eligible for Medicare? ☐ Yes ☐ No

If yes, name of Medicare Eligible Member(s): ____

And if yes, is Medicare eligibility due to a disability? ☐ Yes ☐ No

And if yes, is Medicare eligibility due to age? ☐ Yes ☐ No

SECTION 7. *Coverage Declination/Waiver* ***(This Section is only for declining coverage)***

To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents:
HEALTH Plan coverage, I **DECLINE** coverage for ☐ Myself ☐ Spouse Only ☐ Children Only ☐ Spouse & Children

Reasons for declining Health Plan Coverage: (check one)

☐ Have coverage under another plan. Employer name and Carrier name: ____
Policy Number # ________________
Indicate who is currently covered under other plans: ☐ Self ☐ Spouse ☐ Child(ren)
☐ Other (explanation required) ____

EMPLOYEE SIGNATURE (If DECLINING) **DECLINATION DATE**
(Sign here only if eligible employee and/or their eligible family members are declining coverage)

SECTION 8. *Signatures*

I hereby declare that to the best of my knowledge and belief the statements and answers to the questions on this form are complete and true. I understand that if any misstatements or omissions are made on this form, they may be the basis for later rescission of the coverage. I understand that if the coverage applied for becomes effective, it will be subject to all the terms of the Group Contract. I am employed by the employer shown on this form, actively at work on a full-time basis, with a normal work week of 30 hours or more. If contributions are required, I authorize my employer to make deductions from my earnings for the cost of participating in my employer's plan provided by United Group Programs, Inc.

Failure to supply an answer to any section on this form may result in delayed eligibility, benefit denial, or total forfeiture of coverage.

Any person who knowingly and with intent to 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.

Authorization for the Release of Medical Information
I hereby expressly authorize United Group Programs, Inc., or a representative of United Group Programs, Inc. to procure from any medical provider, to include but not limited to, any licensed physicians; medical practitioner; hospital; clinic or like facility; insurance company; the Medical Information Bureau, Inc.; or other organization; institution or person and to review any and all medical records or documentation created as a result of any treatment or services received under my medical program from this date forward. UGP is authorized to use these records as required to assist in the paying of the medical bills incurred during my participation in the medical program. A photocopy of this form will be valid as the original.

Late Enrollee Warning
An employee or an employee's eligible dependents, who do not enroll during the initial new hire enrollment period and subsequently enroll at a later date during an open enrollment period or utilizing a qualifying life event, shall be considered Late Enrollees.

Employee Signature (IF ACCEPTING) **Date**