ENROLLMENT/CHANGE FORM

( ) New Hire ( ) Change ( ) Termination ( ) Disability ( ) Retirement **Effective:_____ / _____ / _____**
Reason for change:_____

Chg ( )	NAME OF EMPLOYER: **CITY OF HIALEAH**	DEPARTMENT:	**( ) UNITED HEATHCARE CHOICE PLUS ( ) COVENTRY ( ) HUMANA**
Chg ( )	**NAME OF EMPLOYEE: Last:**	**FIRST:**	**MIDDLE:**
Chg ( )	ADDRESS: Number & Street:		Apt. #:
Chg ( )	City:	State: Zip:	Phone:

( ) Male ( ) Female	( ) Active ( ) Retired ( ) Cobra	Hire/Rehire Date: / /	Date of Birth: / /	Social Sec. #: - -	( ) single ( ) widowed ( ) married ( ) divorced ( ) Date: / /

PLEASE COMPLETE ALL APPLICABLE BENEFIT SELECTIONS

I am enrolling/enrolled in:	SINGLE	DOUBLE	FAMILY	I want to change to:	SINGLE	DOUBLE	FAMILY
Medical Benefits				Medical Benefits			

Eligible Dependents: Last Name	First Name	Social Security Number	Relationship	Birth Date	Sex	Other Insurance:	
Spouse:					( ) Male ( ) Female	( ) Yes ( ) No	
**Child:					( ) Male ( ) Female	( ) Yes ( ) No	
**Child:					( ) Male ( ) Female	( ) Yes ( ) No	
**Child:					( ) Male ( ) Female	( ) Yes ( ) No	
**Child:					( ) Male ( ) Female	( ) Yes ( ) No	

* Relationship examples: spouse, son, daughter, stepchild, adopted child, other (specify).
** Proof of dependent eligibility may be required.

PRIOR COVERAGE INFORMATION

You may be eligible for pre-existing condition limitation credit. Please attach a certificate from your prior carrier for pre-existing credit.

Prior Medical insurer _____ Effective Date _____ Termination date_____
Phone Number of Prior Insurer_____
Name of Policy Holder _____ Policy ID Number _____

OTHER INSURANCE

Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: ( ) Single ( ) Family
Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: ( ) Single ( ) Family
Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: ( ) Single ( ) Family

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactively termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to United Healthcare. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

By my signature below, I also acknowedge that a copy of the Notice of Privacy Practices (HIPPA) & Summary Plan Description are available on the Risk Management page of the City of Hialeah website.

Signature of Employee_____ Date Signed_____

Signature of Employer _____ Date Signed_____

COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE COVERAGE

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document. I understand that by waiving coverage, I am also waiving my right to participate in the City's Group Life Program.

Waiver of Coverage for: ( ) Medical/Group Life Reason for Waiving:_____

Signature of Employee _____ Date Signed_____

TO BE COMPLETED BY THE RISK MANAGEMENT DIVISION

General Employees	Sworn Police	Sworn Firefighters
Carrier	Rate: Bi-Weekly	Rate: Monthly

Comments:_____
_____

Notified Payroll_____ Notified Retirement_____

(mav/United Enrollment.Form.xls)