

員工投保登記表/ Employee Enrollment Form

UnitedHealthCare Insurance Company
UnitedHealthCare of Texas, Inc.
National Pacific Dental, Inc.
Unimerica Insurance Company
PacifiCare Life & Health Insurance Company



如欲加速投保流程，請務必完整填寫所有該填的部分。/To speed the enrollment process, please be thorough and fill out all sections that apply.

團體名稱 / 編號/Group Name/Number

由雇主填寫/To Be Completed by Employer

要求的承保生效日期 / 變更日期/Requested Effective Date of Coverage/Date of Change

聘雇日期/Date of Hire / /

職位 / 職稱/Position/Title

每週工作時數/Hours Worked per week

薪資/Salary \$_____ 若人壽保險計畫以薪資為基準才需填寫/Required only if Life Plan based on salary

申請原因/Reason for Application

新團體計畫/New Group Plan

新進人員/New Hire

人生重大事件 / 日期/
Life Event/Date _____

年度開放投保/
Annual Open Enrollment

身分變更/Status Change _____

新增 / 刪除眷屬
/Dependent Add/Delete

變更姓名 / 地址/
Change Name/Address

延遲的投保人/Late Enrollee

其他/Other _____

員工類型 (勾選所有適用項目)/
Employee Type (Check all that apply)

在職/Active

COBRA / 州持續承保/
COBRA/State Continuation
開始日期/Start dt ___/___/___
結束日期/End dt ___/___/___

時薪/Hourly 薪資/Salary

工會/Union 非工會/Non-Union

退休/Retired

其他/Other _____

A. 員工資訊/Employee Information

姓氏/Last Name	名字/First Name	中間名首字母/ MI	社會安全號碼/ Social Security Number	住家電話/Home Phone
				公司電話/Work Phone

地址/Address	公寓號碼/Apt #	城市/City	州/State	郵遞區號/Zip Code	電子郵件地址/Email Address
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出生日期/Date of Birth / /	性別/Sex <input type="checkbox"/> 男性/M <input type="checkbox"/> 女性/F	身高/Height	體重/Weight	過去 12 個月內是否曾 使用菸草? /Used tobacco in the last 12 months? <input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No	慣用語言 (若非英文請填寫)/ Language preference, if not English
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婚姻狀態/Marital Status <input type="checkbox"/> 單身/Single <input type="checkbox"/> 已婚/Married <input type="checkbox"/> 離婚/Divorced <input type="checkbox"/> 喪偶/Widowed	醫師 (完整姓名) / 編號 (僅供 HMO 使用)/ Physician (First & Last Name)/ ID # (HMO use only)	主治牙醫 (完整姓名) / 編號 (僅供 DMO 使用)/ Primary Care Dentist (First & Last Name)/ ID # (DMO use only)
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您是否有影響您溝通或閱讀能力的殘疾? /Do you have a disability affecting your ability to communicate or read? 是/Yes 否/No

HMO 女性投保人無須選擇產科或婦科醫師。產科或婦科照護可由其主治醫師、主要照護服務提供者、產科醫師或婦科醫師提供。/
HMO Female enrollees are not required to select an obstetrician or gynecologist. Obstetrical or gynecological care can be received from her primary care physician, primary care provider or an obstetrician or gynecologist.

B. 家庭資訊/Family Information			列出所有要保者 (如有需要請加頁)/List All Enrolling (Attach sheet if necessary)								
姓氏/ Last Name	名字/ First Name	中間名 首字母/MI	性別/ Sex	關係/ Relationship	出生日期/ Birthdate	身高/ Height	體重/ Weight	全職學生/ Full Time Student	醫師 (姓名 / 編號) 僅供 HMO 使用/Physician (Name/ID#) HMO use only	曾使用 菸草/ Tobacco Used	
社會安全號碼/ Social Security Number									主治牙醫 (姓名 / 編號) 僅供 DMO 使用/ Primary Care Used Dentist (Name/ID#) DMO use only		
			男性/M 女性/F	配偶/ Spouse						<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No	
			男性/M 女性/F	受撫養人/ Dependent				<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No		<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No	
			男性/M 女性/F	受撫養人/ Dependent				<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No		<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No	
			男性/M 女性/F	受撫養人/ Dependent				<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No		<input type="checkbox"/> 是/Yes <input type="checkbox"/> 否/No	
C. 產品選擇 /Product Selection			請勾選所有適用的產品。福利內容須視雇主選擇而定。/Please check all that apply. Benefit offerings are dependent upon employer selection.							選擇的雙重選項計畫/ Dual Option Plan Selected	
個人/ Person	醫療/ Medical	牙科/ Dental	視力/ Vision	人壽保險 / 金額/ Life/Amount	補充人壽保險/ Sup Life	補充 AD&D/ Sup AD&D	STD/ STD	LTD/ LTD	醫療/ Medical	牙科/ Dental	
員工/ Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
配偶/ Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
受撫養人/ Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
人壽保險受益人的全名和地址/ Life Insurance Beneficiary's Full Name and Address									關係/ Relationship		

由「UnitedHealthcare 和關係企業」提供的承保：

醫療承保是由 United HealthCare Insurance Company (PPO、補償式) 或 United HealthCare of Texas, Inc. (HMO) 或 PacifiCare Life & Health Insurance Company (PPO、補償式) 提供

牙科承保是由 United HealthCare Insurance Company (補償式) 或 National Pacific Dental, Inc. (DMO) 提供

人壽保險承保是由 United HealthCare Insurance Company 或 Unimerica Insurance Company 提供

視力承保是由 United HealthCare Insurance Company (PPO、補償式) 或 Unimerica Insurance Company (PPO、補償式) 提供

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company (PPO, indemnity) or United HealthCare of Texas, Inc. (HMO) or PacifiCare Life & Health Insurance Company (PPO, indemnity)

Dental coverage United HealthCare Insurance Company (indemnity) or National Pacific Dental, Inc. (DMO)

Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

Vision coverage provided by United HealthCare Insurance Company (PPO, indemnity) or Unimerica Insurance Company (PPO, indemnity)

D. 先前醫療保險資訊/Prior Medical Insurance Information

如欲以先前的醫療承保扣抵，請務必填寫本部分。/This section must be completed to receive credit for prior medical coverage.

過去 12 個月內，您本人、配偶或受撫養人是否曾有任何其他醫療承保?/Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage? 否/NO 是 (若答是，請填寫本部分。)/YES (if yes, please complete this section.)

先前醫療保險公司名稱/Prior medical carrier name _____

生效日期/Effective date ____/____/____ 結束日期/End date ____/____/____

先前承保類型/Prior coverage type: 員工/Employee 配偶/Spouse 子女/Child(ren) 家庭/Family

E. 其他醫療承保資訊/Other Medical Coverage Information

本部分必須填寫。(如有需要請加頁。)/This section must be completed. (Attach sheet if necessary.)

在本承保開始當日，您本人、配偶或任何受撫養人是否會有任何其他醫療健保計畫或保單 (包括另一個 UnitedHealthcare 計畫、PacifiCare 計畫或 Medicare) 的承保?/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, PacifiCare plan, or Medicare?

是 (繼續填寫本部分)/YES (continue completing this section) 否 (跳過本部分其餘問題)/NO (skip the rest of this section)

其他保險公司名稱/Name of other carrier _____

其他團體醫療承保資訊 (僅需列出由其他計畫承保的人)/ Other Group Medical Coverage Information (only list those covered by other plan)	類型 (B/S/F)*/ Type (B/S/F)*	生效日期 月 / 日 / 年/ Effective Date MM/DD/YY	結束日期 月 / 日 / 年/ End Date MM/DD/YY	其他承保保單持有者的姓名和出生日期/ Name and date of birth of policyholder for other coverage
員工/Employee:				
配偶姓名/Spouse Name:				
受撫養人姓名/Dependent Name:				
受撫養人姓名/Dependent Name:				
受撫養人姓名/Dependent Name:				

*B. 本受撫養人若同時由您和您配偶兩人的保險計畫承保時，則填「B」(已婚者)。/ *B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married).

S. 如果您是受撫養人的監護父母且其他人皆無須支付本受撫養人的醫療費用時，則填「S」。/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. 如果本受撫養人是由其他人 (不是您的家庭成員) 的計畫所承保且該個人必須支付本受撫養人的醫療費用時，則填「F」。/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 – 員工資訊:

Medicare – Employee Information:

已參加 A 部分: 生效日期/

Enrolled in Part A: Effective Date _____

已參加 B 部分: 生效日期/

Enrolled in Part B: Effective Date _____

已參加 D 部分: 生效日期/

Enrolled in Part D: Effective Date _____

符合 Medicare 資格的原因/Reason for Medicare eligibility: 65 歲以上/Over 65

殘疾/Disabled

若已參加 Medicare，請附您的 Medicare 會員卡影本。/

If enrolled in Medicare, please attach a copy of your Medicare ID card.

不符合 A 部分資格*/

Ineligible for Part A*

不符合 B 部分資格*/

Ineligible for Part B*

不符合 D 部分資格*/

Ineligible for Part D*

未參加 A 部分 (選擇不參加)**/

Not Enrolled in Part A (chose not to enroll)**

未參加 B 部分 (選擇不參加)**/

Not Enrolled in Part B (chose not to enroll)**

未參加 D 部分 (選擇不參加)**/

Not Enrolled in Part D (chose not to enroll)**

腎臟病/Kidney Disease

殘疾，但仍在職/Disabled but actively at work

您目前是否有社會安全殘疾保險 (SSDI)?/Are you receiving Social Security Disability Insurance (SSDI)?

是/YES 否/NO 開始日期/Start Date ____/____/____

Medicare – 配偶 / 受撫養人姓名/Medicare – Spouse/Dependent Name:

已參加 A 部分: 生效日期/

Enrolled in Part A: Effective Date _____

已參加 B 部分: 生效日期/

Enrolled in Part B: Effective Date _____

已參加 D 部分: 生效日期/

Enrolled in Part D: Effective Date _____

符合 Medicare 資格的原因/Reason for Medicare eligibility: 65 歲以上/Over 65

殘疾/Disabled

未參加 A 部分 (選擇不參加)**/

Not Enrolled in Part A (chose not to enroll)**

未參加 B 部分 (選擇不參加)**/

Not Enrolled in Part B (chose not to enroll)**

未參加 D 部分 (選擇不參加)**/

Not Enrolled in Part D (chose not to enroll)**

腎臟病/Kidney Disease

殘疾，但仍在職/Disabled but actively at work

* 如果您有收到社會安全福利文件指出您不符合 Medicare 資格，才勾選「不符合資格」。/ * Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** 若您符合 Medicare 為主要計畫的資格 (即 Medicare 先給付福利，之後團體保單才給付)，您應視適用情況參加並維持 Medicare A 部分、B 部分和 (或) D 部分的承保。/ ** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. 病史/Medical History

員工姓名/Employee Name _____

社會安全號碼/SSN _____

團體名稱/Group Name _____

請為您自己以及本登記表第二頁 B 部分「家庭資訊」中所列的每個人回答下列問題。請完整詳實地回答。請注意，若您省略資訊或陳述不實資訊，我們可以變更您的保費。/Please answer the following questions for yourself and each person listed in Section B "Family Information" on the second page of this form. Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may change your premium.**

- 是/Yes 否/No 1. 本申請表上是否有任何人目前懷孕？若答「是」，請提供詳細資訊，包括預產期、任何妊娠併發症、懷有多胞胎和(或)將執行剖腹產。/Is anyone on this application currently pregnant? If "yes" please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section.
- 是/Yes 否/No 2. 本申請表上是否有任何人在過去 10 年內曾因任何疾病、傷害或健康病況而由健康照護專業人員看診？若答「是」，請在下頁提供每個相關個人的詳細資訊。/Has anyone on this application visited any health care professional during the last 10 years for any illness, injury, or health condition? If your answer is "yes" please provide detailed information on next page for each person involved.
- 是/Yes 否/No 3. 本申請表上是否有任何人在過去 12 個月內曾經住醫治療(住院或門診)或接受過外科手術？若答「是」，請在下頁提供每個相關個人的詳細資訊。/Has anyone on this application been hospitalized (inpatient or outpatient) or had surgery in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.
- 是/Yes 否/No 4. 本申請表上是否有任何人在過去 12 個月內曾經取得處方或服用任何處方藥物？若答「是」，請在下頁提供每個相關個人的詳細資訊。/Has anyone on this application been prescribed or taken any prescription medications in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.
- 是/Yes 否/No 5. 本申請表上是否有任何人患有可能需要治療或外科手術的健康病況、疾病或傷害，或是否有任何人曾被健康照護專業人員建議應進行但尚未進行的治療或外科手術？若以上兩個問題之一答「是」，請在下面提供每個相關個人的詳細資訊。/Does anyone on this application have a health condition, illness, or injury that may require treatment or surgery, or has any health care professional recommended treatment or surgery for any of you that has not been performed? If your answer to either question is "yes" please provide detailed information below for each person involved.

請針對以上答「是」的所有問題提供詳細資訊。(若需要更多空間填寫，請另外加頁且務必在該頁面上簽名與加註日期。)/Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)

問題編號/ Question #	個人/ Person	病況 / 診斷/ Condition/Diagnosis	治療 / 藥物/ Treatment/Meds	醫師姓名/ Physician's Name	治療日期/ Dates Treated	預後/ Prognosis

G. 放棄承保/ Waiver of Coverage

我為下列個人拒絕所有承保/
I decline all coverage for:

- 我本人/Myself
 配偶/Spouse
 受撫養子女/Dependent Children
 我本人和所有受撫養人/
Myself and all dependents

因有其他承保而拒絕承保/Declining coverage due to existence of other coverage:

- 配偶雇主的計畫/Spouse's Employer's Plan
 個人計畫/Individual Plan
 Medicare 承保/Covered by Medicare
 Medicaid
 前雇主的 COBRA/COBRA from Prior Employer
 退伍軍人資格/VA Eligibility
 Tri-Care
 我(我們)現在沒有其他承保/I (we) have no other coverage at this time
 其他/Other _____

我瞭解，現在放棄承保就表示我將不得參加計畫，除非我遭遇到改變生活的事件、在下個開放投保期間投保或以延遲的投保人身分投保(如適用)。我也瞭解，就如同和本登記表同時收到的「權利與責任手冊」中所述，我可能須受既有病況限制(PPO)的規範。/I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations (PPO) may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

日期/Date _____

員工簽名(若放棄承保)/Employee Signature if waiving coverage _____

H. 簽名/Signature

我授權 United HealthCare Insurance Company 與其關係企業 (「UnitedHealthcare 和關係企業」) 可取得、使用和透露我的醫療、理賠或福利紀錄，包括這些紀錄中任何可辨識個人身分的健康資訊。我瞭解，這些紀錄可能包括其他個人或實體 (包括健康照護服務提供者) 所建立的資訊，以及與藥物 / 酒精使用、HIV/AIDS、精神健康 (不含心理治療病歷)、性病和生殖健康服務有關的資訊。我授權任何健康照護服務提供者、藥局福利經理、其他保險公司或再保險公司、醫院、診所或其他醫療機構、健康照護資料交換中心，以及任何其關係企業、代表或業務夥伴，均可透露我的資訊給 UnitedHealthcare 和關係企業。我瞭解，透露和使用我的資訊是為了讓 UnitedHealthcare 和關係企業可以做成有關資格、投保、核保和保費風險評級的決定。我瞭解本授權屬於自願性質，我可以拒絕簽署授權。不過，拒絕簽署可能會影響我的健保計畫費率或福利 (法律範圍內)。我瞭解，我可隨時以書面形式通知我的 UnitedHealthcare 和關係企業代表撤銷此一授權，但已依據本授權採取之行動除外。根據 HIPAA 規定，UnitedHealthcare 和關係企業也會要求我確認下列事項，而我也確認：我瞭解，我授權個人或實體取得和使用的資訊可能被再透露且不再受聯邦隱私法規保護。除非提前撤銷，否則本授權有效期間為簽署日期後 30 個月。

我瞭解，我填寫的是人壽和健保計畫合併申請表，每一個回答都必須完整且正確。我 (我們) 是為我本人並為我的受撫養人 (若計畫提供申請指明的團體醫療承保。我授權從工資中扣除必要的保費。我 (我們) 並未將未包括在本申請表的任何健康資訊交給代理人或任何其他個人。我 (我們) 瞭解，如果我 (我們) 向任何代理人或任何其他個人所做的聲明並未寫於或列印於本申請表 and 任何附件中，UnitedHealthcare 和關係企業即不受相關聲明的約束。請保存一份本授權書複本做為您的留底。

I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my rates or benefits in a health plan, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. Please maintain a copy of this authorization for your records.

日期/Date	員工簽名 (代表所有申請人簽名)/Employee Signature for all applying	配偶簽名 (若申請承保)/Spouse Signature (if applying for coverage)
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I. 人口普查統計資訊 (非必填)/Census Information (optional)

備註：本問題非必填，您可選擇回答與否。本部分所收集的資訊僅會用來幫助與投保人溝通，以及告知投保人增進保健的特定方案。本資訊不會用於資格審查流程。/NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. 種族 (勾選所有適用項目)/Race, check all that apply:

- 白人/White 黑人，非裔美國人/Black, African-American 美國印地安人 / 阿拉斯加原住民/American Indian/Alaska Native
 亞裔/Asian 夏威夷原住民 / 太平洋島裔/Native Hawaiian/Pacific Islander
 其他種族，請說明 /Other Race, please specify _____

2. 您是否為西裔或拉丁裔？/Are you of Hispanic or Latino origin? 是/Yes 否/No