

HMO CHANGE APPLICATION

United HealthCare of North Carolina, Inc.

PLEASE TYPE OR PRINT. PRESS FIRMLY

| | | |
|---|--|----------------------------|
| Company Name | United HealthCare of North Carolina ID Number | Social Security No. |
| Employee's Name (As it appears on ID card) | Reason for Change | |
| <input type="checkbox"/> Delete Employee - Effective Date: | | |

Changes to employee address/name (enter **only** those data elements you wish to change)

| | |
|---------------------|-------------------|
| Name | Effective Date |
| Address, City, Zip | Dept. Billing No. |
| Home Phone | Date of Birth |
| Marital Status | Marriage Date |
| Primary Care Doctor | Effective Date |
| | Date of Divorce |

Change/Add Dependents Note: When adding dependent children below, including Alternate Recipients, number according to birth sequence.

| Check Appropriate Box | | Full Name and Relationship (i.e. Son, Daughter) | Social Security Number | Sex | Birthdate | Effective Date | If child is over age 19, please indicate status and school name |
|-------------------------|----|---|------------------------|-----|-----------|----------------|---|
| Change Add Delete | 01 | SPOUSE | | M | | | |
| | | | | F | | | |
| | | | | | | | <input type="checkbox"/> Student at: |
| Change Add Delete | 02 | | | M | | | <input type="checkbox"/> Student at: |
| | | | | F | | | <input type="checkbox"/> Handicapped |
| | | | | | | | <input type="checkbox"/> Student at: |
| Change Add Delete | 03 | | | M | | | <input type="checkbox"/> Student at: |
| | | | | F | | | <input type="checkbox"/> Handicapped |
| | | | | | | | <input type="checkbox"/> Student at: |
| Change Add Delete | 04 | | | M | | | <input type="checkbox"/> Student at: |
| | | | | F | | | <input type="checkbox"/> Handicapped |
| | | | | | | | <input type="checkbox"/> Student at: |

Other Health Insurance Information: On the day your coverage begins, will any family members, including those not listed above, be covered by other health insurance or Medicare? YES NO If yes, fill out this section.

| | | | |
|---|--|---|------------------------|
| Coverage type: | <input type="checkbox"/> Medical Ins. <input type="checkbox"/> Medicare | Insurance Company Name and Phone Number | Policy Number |
| Policy Coverage Dates _____ to _____ | Name of Policyholder | Policyholder's Birthdate | Family Members Covered |
| Policyholder's Employer: | | | |
| Name: | Address: | Phone Number: | |
| Names of family members covered by Medicare | Medicare Claim Number | Part A Effective Date | Part B Effective Date |
| Is Medicare eligibility due to: <input type="checkbox"/> Kidney failure <input type="checkbox"/> Handicapped <input type="checkbox"/> Age | | | |

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give United HealthCare of North Carolina (and any of its accrediting bodies) or any of its designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research uses. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly by Us on this application may invalidate my and/or my dependents' coverage.

Signature _____ Date _____

Employer Signature _____ Date _____