UNITE HERE HEALTH

Dependent Enrollment Form

Plan 173

UNITE HERE! Staff Health Benefits Plan

How to fill out this form:

- Fill out Sections 1, 2, and 3.
- **Other Information Required:** You must send proof of dependent status along with this completed form. See below.

Return this completed form to:

UNITE HERE HEALTH
PO Box 5348
Oak Brook, IL 60522-5348

Fax: (630) 236-4392
Phone: (866) 686-0003
www.uhh.org

Section 1: Employee Information

I am enrolling for the following coverage: ❑ **Employee Only** ❑ **Employee + Family**

Last Name	First	Middle	Date of Birth (month-day-year)	Gender ❑ Male ❑ Female

Street	Apt #	Home Phone ( )	Cell Phone ( )

City	County	State	Zip

Social Security # - -	Employer Name	Employer Address	Hire Date

Language Preference for Healthcare Communications ❑ English ❑ Spanish ❑ Other:	Email

Section 2: Dependent Information

You must provide all information requested below for each dependent.

❑ **Spouse** ❑ **Domestic Partner**

Last Name	First	Gender ❑ M ❑ F	Date of Birth (month-day-year)	Social Security #

Is person employed? ❑ Yes ❑ No	If yes, what is the employer name and address?	Does person have other insurance? ❑ Yes ❑ No	If yes, what is the carrier name?	What is the policy #?

Children *Use another form or other paper for more dependents.*

Last Name	First	Gender	Date of Birth	Social Security #	Please complete if child has other insurance.
		❑ M ❑ F			Carrier Policy # Type
		❑ M ❑ F			Carrier Policy # Type
		❑ M ❑ F			Carrier Policy # Type
		❑ M ❑ F			Carrier Policy # Type
		❑ M ❑ F			Carrier Policy # Type

Other information required for new dependents: *In addition to this completed enrollment form, you must also provide a copy of one of the documents listed to prove a person's dependent status for benefit purposes. If you are enrolling your child, the document you provide must contain the names of the child's parents.*

Dependent Coverage will not begin, and benefit claims for your dependents cannot be paid, until we receive the required documentation.

If you are enrolling your same-sex or opposite-sex domestic partner, a copy of an Affidavit of Domestic Partnership or similar documentation must be provided, as well as 2 documents showing financial interdependence.

- *Marriage certificate (for your spouse)*
- *Birth certificate (for your children)*
- *In certain circumstances, UNITE HERE HEALTH accepts other documents for identification. Call your regional office for more information.*

Section 3: Sign Here

I understand that knowingly enrolling someone who does not qualify for coverage under UNITE HERE HEALTH's dependent enrollment criteria could be grounds for the suspension or termination of my coverage, and that if I enroll someone who does not qualify as my dependent, I will be liable to UNITE HERE HEALTH for any benefits or premiums UNITE HERE HEALTH pays on behalf of that person.

I hereby certify that my dependents listed above meet UNITE HERE HEALTH's dependent enrollment criteria and that the information I have provided on this Enrollment Form is true and correct.

Print Name _____

Signature _____

Date _____