

## **MEMBER RIGHTS REGARDING THE USE AND RELEASE OF GENETIC INFORMATION**

In accordance with Louisiana R.S. 22:1023 and Department of Insurance Regulation 63, this disclosure is to advise the Member of rights concerning the release and use of Genetic Information.

The results of any genetic test, including genetic test information, shall not be used as a basis to:

- a. Terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family member.
- b. Cancel or refuse to renew the coverage of an individual or family member under the policy or plan
- c. Deny coverage or exclude an individual or family member from coverage under the policy or plan.
- d. Impose a rider that excludes coverage for certain benefits or services under the policy or plan.
- e. Establish differentials in premium rates or cost sharing for coverage under the policy or plan.
- f. Otherwise discriminate against an individual or family member in the provision of insurance.

UnitedHealthcare shall not require an applicant for coverage under the policy or plan, or an individual or family member who is presently covered under a policy or plan, to be the subject of a Genetic Test or to be subjected to questions relating to Genetic Information. A Member's Genetic Information is the property of the Member. No person shall retain Genetic Information without first obtaining authorization from the Member or duly authorized representative, unless retention is:

- a. For the purposes of a criminal or death investigation or criminal or juvenile proceeding: or
- b. To determine paternity.

UnitedHealthcare shall not obtain Genetic Information from a Member, or from their DNA sample, without first obtaining written informed consent from the Member, or their representative. To be valid an authorization for Disclosure of Genetic Information shall:

- a. Be in writing, signed by the individual and dated on the date of such signature.
- b. Identify the person permitted to make the disclosure.
- c. Identify the person to whom the information is to be disclosed.
- d. Describe with specificity the purpose for which this disclosure is being made.
- e. State the date upon which the authorization will expire, which in no event will be sixty (60) days after the date of authorization.

The authorization is subject to revocation at anytime before the disclosure is actually made or the individual is made aware of the details of the Genetic Information. The authorization shall be invalid if used for any purpose other than the described purpose for which the disclosure is made. The Member will be provided with a copy of the authorization. The Member may revoke or amend the authorization, in whole or in part at any time. A general authorization for the release of medical records or medical information shall not be construed as an authorization for disclosure of Genetic Information. With respect to medical records that contain Genetic Information, the requirements for disclosure of Genetic Information must be complied with.



**D. Prior Medical Insurance Information**

This section must be completed to receive credit for prior medical coverage.

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

 NO  YES (if yes, please complete this section.)

Prior medical carrier name \_\_\_\_\_ Effective date \_\_\_/\_\_\_/\_\_\_ End date \_\_\_/\_\_\_/\_\_\_

Prior coverage type:  Employee  Spouse  Child(ren)  Family**E. Other Medical Coverage Information**

This section must be completed. (Attach sheet if necessary.)

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 or Medicare?  YES (continue completing this section)  NO (skip the rest of this section)

Name of other carrier \_\_\_\_\_

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

\*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

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. 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 – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

 Enrolled in Part A: Effective Date \_\_\_\_\_  Ineligible for Part A\*  Not Enrolled in Part A (chose not to enroll)\*\* Enrolled in Part B: Effective Date \_\_\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chose not to enroll)\*\* Enrolled in Part D: Effective Date \_\_\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chose not to enroll)\*\*Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at workAre you receiving Social Security Disability Insurance (SSDI)?  YES  NO Start Date \_\_\_/\_\_\_/\_\_\_

Medicare – Spouse/Dependent Name: \_\_\_\_\_

 Enrolled in Part A: Effective Date \_\_\_\_\_  Ineligible for Part A\*  Not Enrolled in Part A (chose not to enroll)\*\* Enrolled in Part B: Effective Date \_\_\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chose not to enroll)\*\* Enrolled in Part D: Effective Date \_\_\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chose not to enroll)\*\*Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at work

\*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

\*\* 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. Medical History**

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_ Group Name \_\_\_\_\_

Have the persons applying for enrollment via this application consulted or been examined or treated by any health care professional during the last 10 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.**

<b>1 Cancer</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____ <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate Stage _____
<b>2 Heart/Circulatory</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Other _____
<b>3 Reproductive</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date _____) <input type="checkbox"/> Multiples (# ___) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Fibroids <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
<b>4 Intestinal/Endocrine</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other _____
<b>5 Brain/Nervous</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Tumor <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Other _____
<b>6 Immune</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Immuno Deficiency <input type="checkbox"/> Other _____
<b>7 Lung/Respiratory</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____
<b>8 Eyes/Ears/Nose/Throat</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____

## F. Medical History (continued)

<b>9 Urinary/Kidney</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
<b>10 Bones/Muscles</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/CFS <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other _____
<b>11 Behavioral Health</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpat ETOH/Drug <input type="checkbox"/> Inpat MH Hosp <input type="checkbox"/> Other _____
<b>12 Transplant</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications Year _____ <input type="checkbox"/> Other _____
<b>13 Medication</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications Please List Meds _____ <input type="checkbox"/> Medications Taken Within The Past Year Please List Meds _____
<b>14 Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised <input type="checkbox"/> Pending Test Results <input type="checkbox"/> Inpat Hosp/Surg in Past Yr. <input type="checkbox"/> Pending w/c claim <input type="checkbox"/> Tests Advised or Recommended <input type="checkbox"/> Refer to Specialist <input type="checkbox"/> Disability

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

## G. Waiver of Coverage

I decline all coverage for:  
 Myself  
 Spouse  
 Dependent Children  
 Myself and all dependents

Declining coverage due to existence of other coverage:

- Spouse's Employer's Plan  Individual Plan  
 Covered by Medicare  Medicaid  
 COBRA from Prior Employer  VA Eligibility  
 Tri-Care  
 I (we) have no other coverage at this time  
 Other \_\_\_\_\_

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 may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date \_\_\_\_\_ Employee Signature if waiving coverage \_\_\_\_\_

## H. Signature

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 ability to enroll in the health plan or receive benefits, 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 or the date that I am no longer covered under the policy(ies), whichever is earlier.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. Any person who knowingly presents a false or fraudulent claim for payment or a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. 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. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Date \_\_\_\_\_ Employee Signature for all applying \_\_\_\_\_ Spouse Signature (if applying for coverage) \_\_\_\_\_

**I. Census Information (optional)**

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.

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1. Race, check all that apply:     White     Black, African-American     American Indian/Alaska Native     Asian  
    Native Hawaiian/Pacific Islander     Other Race, please specify \_\_\_\_\_

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2. Are you of Hispanic or Latino origin?     Yes     No

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I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.

I authorize any required premium contributions to be deducted from earnings.

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application, or until the date that I (we) am (are) no longer covered under the policy(ies), whichever is earlier. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) 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 the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

### **CONFIDENTIALITY**

Make sure your employer has completed the "To be completed by the employer" section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



## **Your rights and responsibilities**





## Important information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at [myuhc.com](http://myuhc.com)<sup>®</sup>.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
  - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
  - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do

we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

### Pre-existing conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under state and/or federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 12 months from the above date. When the preexisting condition is a severe mental illness or other mental disorder, a group health plan may exclude benefits for up to 12 months from the above date or the date you have been enrolled for coverage under the Policy for a period of 60 days, whichever is earlier. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn

child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under state and/or federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

### Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.