Employee Enrollment for Additional Dependents

UnitedHealthcare®
A UnitedHealth Group Company

Employee Name ______________________ **SSN** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Last Name First Name MI Social Security Number	Sex	Relationship	Birthdate	Height	Weight	Full Time Student	*Physician (First and Last Name)	Tobacco Used
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No
___ ___ ___ - ___ ___ - ___ ___ ___ ___	M F					☐ Yes ☐ No		☐ Yes ☐ No

Health information for dependents listed on this addendum, if required for enrollment, has been included in the Medical History section of the Employee Enrollment Form.

Date	Employee Signature	Spouse Signature (if possible and applicable)