



Group: _____

Please respond by: _____

UnitedHealth Allies Enrollment Form

About UnitedHealth Allies

Program Level: The following services are available to your group:

- Vision
- Dental
- Alternative Medicine
- Wellness
- Long-Term Care
- Hearing
- Infertility

About You

Applicant's Name (First, Middle, Last) _____ Daytime Phone Number _____

Street Address _____ City _____ State _____ ZIP Code _____

Date of Birth _____ Email _____ Gender: Male Female

About Your Family

Spouse Information

Name (First, Middle, Last) _____ Daytime Phone Number _____

Street Address _____ City _____ State _____ ZIP Code _____

Date of Birth _____ Email: _____ Gender: Male Female

Dependent Information *List additional children on a separate sheet of paper.*

Child 1 Male Female _____
Name _____
Date of Birth _____

Child 2 Male Female _____
Name _____
Date of Birth _____

Child 3 Male Female _____
Name _____
Date of Birth _____

Membership Fees

- Non-contributory program** (no charge to the employee)
- Contributory program:** The fee per employee is _____ per month. This fee provides discounts for you and your family.

For the contributory program, please complete the following Payroll Deduction Authorization (if applicable):

I authorize the fee of \$ _____ per month for this program to be deducted from my salary and forwarded to HealthAllies. I understand that a photocopy of this form is as valid as the original, and I have a right to receive a copy of this form upon request.

Applicant's Signature _____

Date _____

*Use of the UnitedHealth Allies program is subject to the terms and conditions that accompany the Membership Card.
Note: HealthAllies does not sell, share, trade, or disclose members' personal information.*

To enroll in UnitedHealth Allies, return your completed, signed, and dated enrollment form to your benefits administrator.