Steven M. Abbadessa, D.O.
2315 Dougherty Ferry Rd
Suite 107
St. Louis, MO 63122
(314) 966-7570
(314) 966-7788 –fax

Attention: Jeff

Company: _____

Date: _____

Fax Number: Jeff@CPDSLLC.com

Number of pages (including cover page): _____

Comments: _____

If you do not receive all of these pages or have problems reading any of the information, please contact the office at the above number.

Kina 54.90 Hrs Reg.

Sondra: 67.84 Reg Hrs 30min OT
4 Holiday
9 Sick Hrs

Karen: 21 colonics
Ule hrs 35 min Reg

angie: 73 Reg 10hrs OT
8 vaca
2.5 Holiday

candace: 36.25 Reg
3 Holiday

Monika: 80 reg 30 min OT
4 Holiday

Form **MO W-4**

Missouri Department of Revenue

Employee's Withholding Allowance Certificate

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

Employee

Full Name	Social Security Number	Filing Status
Candace Zimmer	350 86 7550	Single ☑ Married ☐ Head of Household ☐
Home Address (Number and Street or Rural Route)	**City or Town**	**State / Zip Code**
804 Marney Lane	Waterloo	62298

1. Allowance For Yourself: Enter 1 for yourself if your filing status is single, married, or head of household	1	1
2. Allowance For Your Spouse: Does your spouse work? ☐ Yes ☐ No If yes, enter 0. If no, enter 1 for your spouse	2	
3. Allowance For Dependents: Enter the number of dependents you will claim on your tax return. Do not claim yourself or your spouse or dependents that your spouse has already claimed on his or her Form MO W-4	3	
4. Additional Allowances: You may claim additional allowances if you itemize your deductions or have other state tax deductions or credits that lower your tax. Enter the number of additional allowances you would like to claim	4	
5. Total Number Of Allowances You Are Claiming: Add Lines 1 through 4 and enter total here	5	1
6. Additional Withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected balance due by the number of pay periods in a year. Enter the additional amount to be withheld each pay period here	6	$
7. Exempt Status: If you had a right to a refund of all of your Missouri income tax withheld last year because you had no tax liability and this year you expect a refund of all Missouri income tax withheld because you expect to have no tax liability, write "Exempt" on Line 7. See information below.	7	
8. If you meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability, write "Exempt" on line 8. See information below.	8	

Signature

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's Signature (Form is not valid unless you sign it)	Date (MM/DD/YYYY)
Candace Zimmer	07/03/2015

Employer

Employer's Name	Employer's Address	
City	State	Zip Code
Date Services for Pay First Performed by Employee (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Federal Employer I.D. Number	Missouri Tax Identification Number

Notice To Employer: Within 20 days of hiring a new employee, send a copy of Form MO W-4 to the Missouri Department of Revenue, P.O. Box 3340, Jefferson City, MO 65105-3340 or fax to (573) 526-8079. Visit **www.dss.mo.gov/cse/newhire.htm** for additional information regarding new hire reporting.

Employee Information — You Do Not Pay Missouri Income Tax on all of the Income You Earn!

Visit **http://www.dort.mo.gov/tax/calculators/withhold/** to try our online withholding calculator.

Form MO W-4 is completed so you can have as much "take-home pay" as possible without an income tax liability due to the state of Missouri when you file your return. Deductions and exemptions reduce the amount of your taxable income. If your income is less than the total of your personal exemption plus your standard deduction, you should mark "Exempt" on Line 7 above. The following amounts of your annual Missouri adjusted gross income will not be taxed by the state of Missouri when you file your individual income tax return.

Single	Married Filing Combined	Head of Household
$2,100 — personal exemption	$ 4,200 — personal exemption	$ 3,500 — personal exemption
$6,300 — standard deduction	$12,600 — standard deduction	$ 9,250 — standard deduction
$8,400 — Total	$16,800 — Combined Total (For both spouses)	$12,750 — Total
+ $1,200 for each dependent	+ $1,200 for each dependent	+ $1,200 for each dependent
+ up to $5,000 for federal tax	+ up to $10,000 for federal tax	+ up to $5,000 for federal tax

Items to Remember:

- If your filing status is married filing combined and your spouse works, do not claim an exemption on Form MO W-4 for your spouse.
- If you and your spouse have dependents, please be sure only one of you claim the dependents on your Form MO W-4. If both spouses claim the dependents as an allowance on Form MO W-4, it may cause you to owe additional Missouri income tax when you file your return.
- If you have more than one employer, you should claim a smaller number or no allowances on each Form MO W-4 filed with employers other than your principal employer so the amount withheld will be closer to your amount of total tax.
- If you itemize your deductions, instead of using the standard deduction, the amount not taxed by Missouri may be a greater or lesser amount.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card.

Form MO W-4 (Revised 12-2014)

Mail to: Taxation Division
P.O. Box 3340
Jefferson City, MO 65105-3340

Phone: (573) 751-8750
Fax: (573) 526-8079

Visit **www.dss.mo.gov/cse/newhire.htm** for additional information.

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	1
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	1
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H	2

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1 Your first name and middle initial: Candace M	Last name: Zimmer	2 Your social security number: 350-86-7550
Home address (number and street or rural route): 804 Mamey Lane	3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code: Waterloo IL 62298	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		5: 2
6 Additional amount, if any, you want withheld from each paycheck		6: $
7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		7:

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ► Candace Zimmer **Date** ► 7/3/15

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. **Read instructions carefully before completing this form. The instructions must be available during completion of this form.**
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*
Zimmer	Candace	M	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
804 Marney Lane		Waterloo	IL	62298

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
02/10/1988	350-86-7550	c2j210@gmail.com	618-719-5050

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- [x] A citizen of the United States
- [ ] A noncitizen national of the United States *(See instructions)*
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee: Candace Zimmer	Date *(mm/dd/yyyy)*: 07/03/15

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: ID Card		Document Title: Social Security Card
Issuing Authority:		Issuing Authority: State of Illinois		Issuing Authority: 350-86-7550
Document Number:		Document Number: 5601-1388-6412		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 02-10-21		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: 06/29/15 **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

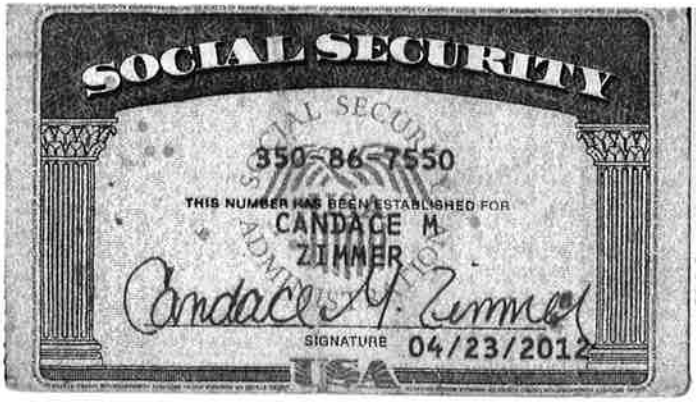
A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:


SOCIAL SECURITY
350-86-7550
THIS NUMBER HAS BEEN ESTABLISHED FOR
CANDACE M
ZIMMER
Candace M. Zimmer
SIGNATURE 04/23/2012
USA


ILLINOIS
Jesse White • Secretary of State
ID CARD
ID. No.: 5601-1388-6417
DOB: 02-10-88
Expires: 02-10-21
Issued: 06-26-15
Class:
Type: ORD
CANDACE M ZIMMER
2607 COLUMBIA LAKES DR
APT 3A
COLUMBIA IL 62236
Candace Zimmer
Female 5'04" 125 lbs HZL Eyes

(DO NOT STAPLE)

Employee Enrollment Form

UnitedHealthcare®

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer

Requested Effective Date of Coverage/Date of Change / /

Group Name		Policy Number
Date of Hire / /	Reason for Application □ New Group Plan □ New Hire □ Life Event/Date____ □ Annual Open Enrollment □ Status Change____ □ Dependent Add/Delete □ Change Name/Address □ Late Enrollee □ Part time to Full time □ Waiving Coverage □ Termination □ Other ____	Employee Type (Check all that apply) □ Active □ COBRA □ State Continuation Start dt __/__/__ End dt__/__/__ □ Hourly □ Salary □ Union □ Non-Union □ Retired □ Other ____
Position/Title		
Hours Worked per week		
Salary $____ Required only if Life, STD, or LTD Plan based on salary		

A. Employee Information

If you are waiving all coverage, please complete sections A and F.

Last Name	First Name	MI	Social Security Number
Zimmer	Candace	M	350-86-7550

Address	Apt #	City	State	Zip Code	Home/Cell Phone
804 Marney lane		Waterloo	IL	62298	618-719-5050

Date of Birth	Gender	Email Address	Work Phone
02/10/1988	□ M ☑ F	c252108@gmail.com	314-966-7570

Marital Status ☑ Single □ Married □ Divorced □ Widowed

Do you use tobacco?[1] □ Yes ☑ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No

Language Preference, if not English

Primary Care Physician[2] Existing Patient? ☑ Yes □ No
Physician First & Last Name Sean Lattimore
Address 2104 Hamacher
ID# _|_|_|_|_|_|_|_|_|_|_|_| - |_|_|

Primary Care Dentist[3]
Dentist First & Last Name
ID#
Existing Patient? □ Yes □ No

B. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex □ M □ F	Date of Birth / /
Spouse	Social Security Number ___-__-____	Do you use tobacco?[1] □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No			

Primary Care Physician[2] Existing Patient? □ Yes □ No
Physician First & Last Name ____
Address ____
ID# _|_|_|_|_|_|_|_|_|_|_|_| - |_|_|

Primary Care Dentist[3]
Dentist First & Last Name ____
ID# ____
Existing Patient? □ Yes □ No

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of the Midwest, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name ____________________

B. Family/Dependent Information (continued)

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | |–| | |–| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ____________________
Address ____________________
ID# __|__|__|__|__|__|__|__|__|__|__|__| – |__|__|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | |–| | |–| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ____________________
Address ____________________
ID# __|__|__|__|__|__|__|__|__|__|__|__| – |__|__|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | |–| | |–| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ____________________
Address ____________________
ID# __|__|__|__|__|__|__|__|__|__|__|__| – |__|__|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | |–| | |–| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ____________________
Address ____________________
ID# __|__|__|__|__|__|__|__|__|__|__|__| – |__|__|

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D	STD	LTD
Employee	☒ ________	☒ ________	☒	☐ $________	☐ $________	☐	☐
Spouse	☐	☐	☐	☐ $________	☐ $________		
Dependent	☐	☐	☐	☐ $________	☐ $________		

This health benefit plan does not include coverage for elective abortions.

Exclusive Provider Organization Notice

This notice applies to managed care health benefit plans that require all health care services be delivered by providers participating in our network.

With the exception of emergency medical conditions, life-threatening conditions, disabling degenerative disease treatments, and certain mental health benefits, this health benefit plan covers only services received by providers participating in our network.

You can opt-out of this health benefit plan and be enrolled in a health benefit plan which includes out-of-network benefits by checking the box on the right. ☐

Employee Name _____

C. Product Selection (continued)

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

D. Prior Medical Insurance Information

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 work

Are 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. 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 qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date	Employee Signature if waiving coverage

G. Signature

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") 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 that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires 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.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare 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.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
7/3/15	Candace Zimmer	

H. 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.

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

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