Employment Eligibility Verification

Please 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 eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Vanderguild	Lena	M	
Address *(Street Name and Number)*		**Apt. #**	**Date of Birth** *(month/day/year)*
123 ABC St		Apt. 2	12/16/1975
City	**State**	**Zip Code**	**Social Security #**
Somecity	MN	99201	548798888

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):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A _____
- ☐ An alien authorized to work until _____

(Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

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.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	**Date** *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date *(if any)*: _____		_____		_____
Document #: _____				
Expiration Date *(if any)*: _____				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	**Address** *(Street Name and Number, City, State, Zip Code)*	**Date** *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

MII Life
An independent licensee of the Blue Cross and Blue Shield Association

DELTA DENTAL
Delta Dental Plan of Minnesota

A. SMALL GROUP EMPLOYEE APPLICATION AND CHANGE FORM –

Read Instructions for Application on Page 4.
Please print all information in black or blue ink.

If your employer has current group coverage with our company, provide the **group and subgroup** numbers:

Health (group and subgroup)	Dental	Life	Short Term Disability	Long Term Disability
__ __ __ __ __ - __ __	__ __ __ __ __ - __ __	__ __ __ __ __ - __ __	__ __ __ __ __ - __ __	__ __ __ __ __ - __ __

Name of Employer	Occupation or Duties
Travel Agency	Manager

Full-time Employment Date	Hours working per week	Work phone	Home phone
	40	2085459999	2085051234

Employee's First Name	M.I.	Last Name	Social Security Number
Jim	A	Johnson	545878999

Date of Birth	Sex	Height	Weight	Primary Care Clinic Number (PCC#) (Required for Blue Plus):
01/11/1970	☑ Male ❑ Female			

Marital Status
❑ Single ☑ Married If married, Date of Marriage: ____/____/____ County and State of Marriage: _____/_____

Employee's Home Address	Street	City	State	Zip code
	123 Some St	Spokane	WA	12345

B. DEPENDENT INFORMATION – List all dependents applying for coverage. Use extra paper if necessary

Name First M.I. Last	Sex	Social Security #	Relation (Circle)	Birth Date (Mo. Day Yr.)	Height	Weight	PCC#	Full-time Student (Age 19+)
			Spouse					
								School Grad. Date_____
								School Grad. Date_____
								School Grad. Date_____
								School Grad. Date_____

C. BENEFIT SELECTION – Your employer decides which benefits are available to employees.

Employees must apply for coverage in order for their dependents to receive coverage.
If you are not applying for coverage, you must still complete this section and sign the application on page 4.

1. Benefit Selection (select the benefits you want and identify which family members are applying or not applying for coverage):

A. Health **Applying for:** ❑ Employee ❑ Spouse ❑ Children **Not Applying for:** ❑ Employee ❑ Spouse ❑ Children

If you are **not applying** for yourself or a family member, provide the reason: ❑ Spouse's group coverage ❑ Individual coverage ❑ Group coverage continuation ❑ No other health coverage ❑ Medicare ❑ Medical Assistance ❑ General Assistance Medical Care ❑ MCHA (effective date of MCHA coverage_____) ❑ Other _____

If your employer offers two health plans, which health plan are you applying for?_____

B. Dental **Applying for:** ❑ Employee ❑ Spouse ❑ Children **Not Applying for:** ❑ Employee ❑ Spouse ❑ Children

If you are **not applying** for yourself or a family member, provide the reason: ❑ Other dental coverage ❑ No other dental coverage

C. Employee Life/AD&D ❑ Applying ❑ Not Applying **D. Dependent Life** ❑ Applying ❑ Not Applying

E. Short Term Disability ❑ Applying ❑ Not Applying **F. Long Term Disability** ❑ Applying ❑ Not Applying

Complete if applying for employee life and/or disability benefits: Annual Salary $_____

Beneficiary Name _____ Relation to Employee _____

If you decide to apply for health coverage at a later date, you and/or your dependents may be subject to an 18-month preexisting condition limitation period. You give up your option for dental benefits if you do not apply for dental coverage when you are first eligible.

UnitedHealthcare®
A UnitedHealth Group Company

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

Group Name/Number: Travel Agency

To Be Completed by Employer

☐ New ☐ Dependent Add/Delete ☐ Change Name/Address ☐ Cancel ☐ Date of Change

Group Specifics

Position/Title: Manager

Hours Worked: 40

Plan Selected
Medical_____
Dental_____

Reason for Application
☐ New Group Plan
☐ Annual Open Enrollment
☐ New Hire
☐ Status Change _____
☐ Life event/date _____
☐ Other _____

Product Selection
Health ☐ Yes ☐ No
Life ☐ Yes ☐ No
$_____
Dep Life ☐ Yes ☐ No
Dental ☐ Yes ☐ No
Vision ☐ Yes ☐ No
Other _____

Employee Type
Active ☐ Yes ☐ No
COBRA./St Cont ☐ Yes ☐ No
Hourly ☐ Yes ☐ No
Salary ☐ Yes ☐ No
Union ☐ Yes ☐ No
Non-Union ☐ Yes ☐ No
Other _____

DATE OF HIRE 05/05/2004

A. Employee Information

First Name	MI	Last Name	Social Security Number	Home Phone / Work Phone
Jim	A	Johnson	545878999	2085051234 / 2085459999

Address	Apt #	City	State	Zip	Email Address
123 Some St		Spokane	WA	12345	

B. Family Information

List All Enrolling (Attach sheet if necessary) **Marital Status** ☐ Single ☑ Married

Last Name First Name MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time	Physician*(First and Last Name)
Employee	☑M ☐F	Self	01/11/1970			☐ Student	
	☐M ☐F	Spouse/Dom. Partner					
	☐M ☐F					☐ Yes ☐ No	

*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents, for UnitedHealthcare Select and Select Plus only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

C. Product Selection

(Please check all that apply)*

Person	Medical	Life	Sup Life	Sup AD&D	Dental	Vision	STD	LTD	Dual Option Plan Number
Employee		$	$	$					
Spouse		$							
Dependents		$							

*Benefit offerings are dependent upon employer election

Life Beneficiary's Full Name and Address

Relationship

D. Other Coverage Information

☐ Yes ☐ No Has anyone on this application been covered with health benefits, including coverage with UnitedHealthcare within the past 2 years?

List dates covered

List all family members covered

☐ Yes ☐ No Are you or any of your dependents covered by Medicare?

Reason ☐ Over 65 ☐ Disabled ☐ Kidney Disease

Covered by Part ☐ A ☐ B

If yes, Name of Medicare Beneficiary

Date Medicare became effective

Claim Number

E. Waiver of Coverage

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

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 ☐ Other _____
☐ I (we) have no other coverage at this time

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.

Employee Initials | Date

F. Signature

I authorize The Company 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 The Company and Affiliates. I understand the purpose of the disclosure and use of my information is to allow The Company 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 The Company in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the 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.

(continued on back)