Product and Benefit Selection Form

UnitedHealthcare

1a. Group Name _____

1b. Identify primary business location _____

1c. List all other locations besides primary business location _____

2. Medical Plan Code(s)

_____

_____

_____

_____

_____

2b. Will this plan co-exist with another health plan?

• Yes • No If yes, name of carrier _____

2c. Prescription Benefit Plan Number (Rx) _____

2d. Deductible Administration

• Calendar Year (from Jan. 1 to Dec. 31)

• Policy/Contract Year (from effective date to renewal date) [(Not applicable to NHP)]

I acknowledge that the health plan selected includes coverage for substance abuse and mental health that is equal to or exceeds coverage as required by Florida Statutes 627.669 and 627.668.

3. Dental Plan Code(s)

_____

_____

3b. Has this group been covered for major dental services for the previous 12 consecutive months?

• Yes • No If yes, name of carrier _____

4. Vision Plan Code(s)

_____

_____

5. Life Amount(s)

Employee $_____

Spouse $_____

Child(ren) $_____

• Yes • No Acceptance of this application will replace existing life insurance coverage.

6. Supplemental Coverage(s)

Life $_____

AD&D $_____

STD $_____

LTD $_____

7. Other Notes