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)

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