UNITEDHEALTHCARE LIFE INSURANCE COMPANY
Application for Insurance

SECTION 1
Applicant(s) Information - Must Be Completed by the Applicant(s)

Please Print In Black Ink

1. REASON FOR APPLICATION:

☐ New Application ☐ Add a dependent ID Number (for additions)

2. PRIMARY APPLICANT'S INFORMATION:

a. Name (Last, First, M.I.): _____

b. Mailing Address

Street (Include Apt.)

City State ZIP

c. **Physical address is required if different than your mailing address. PO Boxes are not accepted as a physical address.**

Street (Include Apt.)

City State ZIP

d. County of Residence _____

e. Phone Numbers ( ) ( )

Home Other Best number and time to call Email Address

f. Payor _____

(If not You) Name Email Address

Street City State ZIP

g. Marital Status: ☐Married ☐Single

3. APPLICANTS FOR COVERAGE: Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date
☐Male ☐Female	a. Primary (You)		
☐Male ☐Female	b. Spouse		
☐Male ☐Female	c. Child		
☐Male ☐Female	d. Child		
☐Male ☐Female	e. Child		
☐Male ☐Female	f. Child		
☐Male ☐Female	g. Child		

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ☐

4. Are all applicants United States citizens or nationals? ..... ☐ YES ☐ NO
(If no, indicate who below and provide the requested information for that person.)

Applicant (same as in Question 3)	Document Type	ID Number
☐ a. Primary		
☐ b. Spouse		
☐ c. Child		
☐ d. Child		
☐ e. Child		
☐ f. Child		
☐ g. Child		

5. In the last 6 months, has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) 4 or more times per week on average, excluding religious or ceremonial uses? ☐ YES ☐ NO

(If yes, indicate who.)
☐ a. Primary ☐ b. Spouse ☐ c. Child ☐ d. Child ☐ e. Child ☐ f. Child ☐ g. Child

SECTION 2

Product Selection & Billing (or attach a health insurance quote). Complete for new applications only.

Requested Effective Date
__ __/__ __/__ __ __ __

Copay Plans
☐ Bronze Copay Select℠ 1
☐ Bronze Copay Select℠ 2
☐ Silver Copay Select℠ 1
☐ Silver Copay Select℠ 2
☐ Silver Copay Select℠ 3
☐ Gold Copay Select℠

HSA Plans
☐ Bronze HSA 100®
☐ Silver HSA 100®

Catastrophic Plan
☐ Select Saver℠

Base Premium Amount *(includes taxes and fees)* $ _____

☐ HSA Deposit + _____

Total Monthly Payment *(Payable to UHCLIC)* = $ _____

If Quarterly, Total Monthly Payment x 3 *(Payable to UHCLIC)* = $ _____

6. Payment:

Initial Payment with Application: ☐ Check ☐ EFT ☐ Credit Card

Ongoing Payments: **Monthly** ☐ EFT ☐ Direct Bill
Quarterly ☐ Direct Bill

IMPORTANT: Electronic Funds Transfer (EFT) and Credit Card payments will be collected on the date we issue coverage, or the effective date of the policy, whichever is later. If Initial Payment is EFT, Ongoing Payment must be EFT. If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt. Premium will be verified and may be adjusted up or down during the processing of your application.

SECTION 3
Medicare Status

7. Is any applicant covered by Medicare? ..... ☐ YES ☐ NO

(If yes, list names below.)

Applicant's Name	Applicant's Name	Applicant's Name

SECTION 4
Special Enrollment

Complete only if applying due to a qualifying event(s). You must provide written proof of eligibility for any of the reasons marked in question 8. Submit copies of documents supporting the occurrence of the event(s).

8. You may be eligible for health insurance coverage under Special Enrollment Periods if at least one of the following events occurred in the last 60 days: (Mark all that may apply, indicate to whom they apply, and answer the corresponding question(s).)

☐ a. Loss of health insurance. Which applicant(s)? _____

i. Did the applicant lose health insurance due to failure to pay premium?..... ☐ YES ☐ NO

a. If yes, the applicant is not eligible for health insurance coverage under a Special Enrollment Period.

b. If no, reason for loss of insurance: _____

ii. Initial effective date of insurance? (MM/DD/YY) ___/_____/____

iii. Termination date of insurance? (MM/DD/YY) ___/_____/____

iv. Type of insurance coverage lost:

☐ Employer Group
☐ COBRA
☐ Short Term
☐ Individual
☐ Medicaid
☐ Other (please specify) _____

v. Prior Insurance Company Name _____

vi. Prior Insurance Company Phone Number _____

vii. Primary Insured/Member's Name and ID Number _____

☐ b. Marriage. Which applicant(s)? _____

i. When did the applicant get married? (MM/DD/YY) ___/_____/____

☐ c. Birth, adoption, or placement for adoption. Which applicant(s)? _____

i. When was the applicant born, adopted, or placed for adoption? (MM/DD/YY) ___/_____/____

☐ d. Move to a different state. Which applicant(s)? _____

i. When did the applicant move? (MM/DD/YY) ___/_____/____

ii. What is the prior address?

_____ | | | | | | |

Street City State ZIP

UHCLIC does not require, ask for or collect genetic testing information. UHCLIC will not, on the basis of any genetic information concerning an individual or family member or on the basis of an individual's or family member's request for or receipt of genetic services, or the refusal to submit to a genetic test or make available the results of a genetic test:

(a) Terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family member.

(b) Cancel or refuse to renew the coverage of an individual or family member under the policy or plan.

(c) Deny coverage or exclude an individual or family member from coverage under the policy or plan.

(d) Impose a rider that excludes coverage for certain benefits or services under the policy or plan.

(e) Establish differentials in premium rates or cost sharing for coverage under the policy or plan.

(f) Otherwise discriminate against an individual or family member in the provision of insurance.

SECTION 5

Statement of Understanding - Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded.

I understand and agree that:

(1) This application and the initial payment do not give me immediate coverage.

(2) I will be the sole source of payment of premium. There is and will be no direct or indirect contribution or reimbursement by or on behalf of any health care provider, health care provider sponsored organization, employer, business, or any other entity for any portion of the premium for coverage under this policy, unless specifically approved in writing by UnitedHealthcare. UnitedHealthcare Life will accept premium payments from the following third parties:
- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.
- The American Kidney Fund.

If self-employed, I may use a business check for my personal insurance.

(3) I should not terminate existing coverage until I have accepted the UnitedHealthcare Life Insurance Company coverage.

(4) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial in cases of fraud or intentional misrepresentation of material fact.**

(5) This completed application, and any supplements or amendments, will be a part of any policy, if issued.

(6) The broker may only submit the application and initial payment, and may not promise me coverage, modify UnitedHealthcare Life's underwriting policy or terms of coverage, or change or waive any right or requirement.

(7) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.

(8) If UnitedHealthcare Life rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by UnitedHealthcare Life does not constitute approval of my application or create UnitedHealthcare Life coverage.

(9) I must select a primary care physician. A primary care physician may be a doctor who is a family practitioner, pediatrician, general practitioner, or internist. If I do not select a primary care physician, one will be assigned to me. Benefits may be reduced if I see a specialist without a referral from my primary care physician.

(10) The policy requires some medical services to be authorized by UnitedHealthcare Life or its representative before the services are provided, and benefits for these services may be reduced if the prior authorization is not obtained.

I have received a Notice of Information Practices and a Conditions Prior to Coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

X _____ / / _____
Primary Applicant (You) Date

X _____
Parent/Guardian (if you are a minor) Relationship

X _____
Spouse (if to be covered)

SECTION 6

Broker Statement: Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____
Signature of Licensed Broker

X _____
Print Full Name

Broker Number

Broker Email Address

Primary Care Physician Selection: **Please select a Primary Care Physician (PCP) from our network who is in your state of residence. If no PCP is listed, we will assign one to you. See our Physician Listing at unitedhealthone.com/doctor.**

	Physician's Name	Phone Number	Office Address	City	State	ZIP
a. Primary (You)					LA	
b. Spouse					LA	
c. Child					LA	
d. Child					LA	
e. Child					LA	
f. Child					LA	
g. Child					LA	

If you need to list Primary Care Physicians for additional dependents, please use lined paper, sign and date it, and check this box. ☐

Authorization to Obtain and Disclose Nonmedical Information

I authorize UnitedHealthcare Life Insurance Company to obtain information that they need to verify my application for insurance. Any employer, insurance company, government agency, or consumer-reporting agency having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to UnitedHealthcare Life Insurance Company.

I (we) have received UnitedHealthcare Life Insurance Company's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UnitedHealthcare Life Insurance Company. I (we) may request revocation of this authorization by writing to UnitedHealthcare Life Insurance Company, as explained in UnitedHealthcare Life Insurance Company's Notice of Information Practices. UnitedHealthcare Life Insurance Company may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

ADNI-UL-1013

I have read the above: Authorization to Obtain and Disclose Nonmedical Information.

X _____ / / _____
Primary Applicant (You) Date

X _____
Spouse (if to be covered)

X _____
Parent/Guardian (if you are a minor) Relationship

Parent/Guardian Information **(if application is for child(ren) only)**

Parent/Guardian Name Email Address

Street City State ZIP

Primary/Spouse Email Addresses

Primary Applicant's Email Address Spouse's Email Address

Health Savings Account (HSA) application — Only if opening an HSA with Optum Bank

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with Optum Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by Optum Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with Optum Bank's Privacy Policy and Schedule of Fees.
- I authorize Optum Bank to provide information about my HSA, including my account number, to UnitedHealthcare Life Insurance Company, and those acting on behalf of UnitedHealthcare Life Insurance Company or Optum Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that UnitedHealthcare Life Insurance Company and all others acting on behalf of UnitedHealthcare Life Insurance Company, may provide information on my behalf to establish and maintain my HSA and authorize UnitedHealthcare Life Insurance Company and its designee to take such action deemed necessary and appropriate by UnitedHealthcare Life Insurance Company to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Optum Bank if I wish to have statements mailed to my home address.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User debit card, I hereby request Optum Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I authorize Optum Bank to share information about my HSA with the Authorized User named, and to allow any account transactions made by such Authorized User.
- I certify that the information provided in this application is true and complete.

X _____

Signature of Primary Applicant

Primary Applicant's Social Security No. | | | | | | | | | |

Applicant's Spouse Social Security No. | | | | | | | | | |

Per the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)

Authorized User's _____
First Name Middle Initial

Authorized User's _____
Last Name

Authorized User's _____
Date of Birth

Authorized User's | | | | | | | | | |
Social Security No.

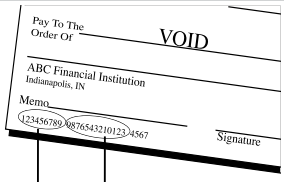
HSA-UL-1013

Electronic Funds Transfer (EFT) Authorization — Only if paying by EFT

I (we) hereby authorize UnitedHealthcare Life Insurance Company to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of Account: ☐ Checking ☐ Savings



Nine-digit Routing No. | | | | | | | | | |

Account No. | | | | | | | | | | | | | | | | | |

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____
Day Date Signed

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X _____
Authorized Account Signature

Email Address _____

EFTTI-UL-1115

Initial Payment Credit Card Authorization

I authorize UnitedHealthcare Life Insurance Company to bill my American Express/MasterCard/Visa account for the Initial Payment. **If quarterly billing requested, the Initial Payment will be for three months plus any one-time costs.**

Type of Card: ☐ MasterCard ☐ Visa ☐ American Express

Exp. Date: | | | Month | | | Year

Billing ZIP Code: | | | | | |

Card Number: | | | | | | | | | | | | | | | | |

X _____
Signature of Authorized User

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

CCTI-UL-1013

UnitedHealthcare Form 1095-B Electronic Delivery Consent Notice

This notice is for electronic delivery of Form 1095-B only. Your consent will stay in place until you tell us that you don't want to get Form 1095-B electronically.

What is Form 1095-B?

This is the IRS form that you will need when you file your federal income tax return to show that you have minimum essential coverage (MEC). The form shows this information about your health coverage:

- Type of coverage you had
- Period of coverage
- Who was covered (including dependents)

Electronic delivery of Form 1095-B

You agree to receive Form 1095-B electronically instead of receiving a paper copy. If you also want a paper copy, call the number on your health plan ID card. We will keep sending future forms electronically.

You may print Form 1095-B to use when completing your tax return.

You may have already agreed to get other communications electronically. We need you to also agree to get Form 1095-B electronically.

To stop getting electronic delivery of Form 1095-B and to get a paper copy

You can stop getting electronic delivery of Form 1095-B at any time and choose to get a paper copy. To do this:

1. Log in to myuhone.com
2. Then click "Profile", then "Account Information" and you'll be able to reset your mailing and email preferences. You will get a confirmation of the change. You can also change these preferences by clicking the "Account Settings for Document Delivery", located on the home page.

You may also send your request in writing to:

UnitedHealthcare
PO Box 31372
Salt Lake City, UT 84131-0372

Be sure to include the following information with your request:

- Primary insured's name
- Date of your request
- Primary insured's email address
- Policy ID Number
- And make sure you sign the request

You can also ask for a free paper copy of Form 1095-B by calling the member phone number on your health plan ID card. We will stop sending Form 1095-B electronically on the date that you tell us not to send it electronically. This will not affect statements that were already provided to you electronically.

Undeliverable Emails

We will notify you via the email address you give us, that your Form 1095-B is available. If we get a message that the email is undeliverable, we will assume that you don't want electronic delivery anymore. We will send a paper copy of Form 1095-B to you. To update your email address:

1. Log in to myuhone.com
2. Then click "Profile", then "Account Information" and you'll be able to reset your mailing and email preferences. You will get a confirmation of the change. You can also change these preferences by clicking the "Account Settings for Document Delivery", located on the home page.

To be sure that you can receive emails from us, add the UnitedHealthcare email address to your email address book or safe list.

If your UnitedHealthcare health plan terminates

If your plan terminates, you will receive Form 1095-B from UnitedHealthcare for the months you had coverage with us.

Requirements to Receive and Keep Electronic Information

To receive and keep electronic information, you must have access to a computer or other device that can get to the Internet and a printer. You must have an email address. Also, you must have Adobe Acrobat Reader® version 6.0 or higher which lets you open Portable Document Format or "PDF" files.

Form 1095-B is available for three years from the year the form was issued.

Primary Applicant's Name

Primary Applicant's Email Address

X

Primary Applicant's Signature

Date

Parent/Guardian (if you are a minor)

Parent/Guardian Email Address

X

Parent/Guardian Signature