Product Selection Form
New Mexico Small Business

UnitedHealthcare®

Multi-Choice Package NM012

Available for effective dates starting 1/1/2022

General Information
Group Name
Agent Name
General Agent (Not required)
Effective Date

Please Indicate Medical Plan Selection

Multi-Choice Package NM012

Select the plans being offered to employees.

Choice Plus Direct

☐	CN-76	15/250/100%	K70L
☐	CN-79	20/100%	K70L
☐	CN-8A	25/500/70%	K70L
☐	CN-77	25/1000/80%	K70L
☐	CN-78	40/4000/80%	K70L
☐	CN-8C	50/5000/80%	K70L
☐	CO-HY	65/6500/50%	K86L

Choice Plus Plans

☐	CN-7E	20/100/90%	K70L
☐	CN-7M	15/500/80%	K70L
☐	CN-7G	50/500/55%	K87L
☐	CN-7H	7/700/70%	K88L
☐	CN-7K	25/1000/80%	K71L
☐	CN-7F	25/2500/80%	K70L
☐	CN-7R	30/2500/70%	K70L
☐	CN-7N	30/3000/80%	K70L
☐	CN-7P	50/3500/80%	K86L
☐	CN-7Q	50/4500/80%	K86L
☐	CN-7O	50/5500/80%	K71L
☐	CN-7Z	8700/100%	E83

Choice Plus HSA Plans

☐	CN-7L	40/2500/80%	K71L
☐	CN-7J	4000/100%	K71L
☐	CN-7S	6000/60%	K70L
☐	CN-7I	7050/100%	E83

If an HSA plan is selected, which bank will be used?   ☐ Optum Bank®   ☐ Other

Bilingual materials and services designed to provide a better health care experience for our Spanish-speaking members through PlanBien® at no additional charge.   ☐ YES   ☐ NO

Group Name: _____

Ancillary Plan Selection(s)

Dental: ☐ Yes ☐ No   ☐ Employer-sponsored   ☐ Voluntary   Plan Code(s): _____ _____

Vision: ☐ Yes ☐ No   ☐ Employer-sponsored   ☐ Voluntary   Plan Code(s): _____

Basic Life/AD&D: Check if Basic Life 100% employer-paid for employees

Flat Benefit Amount

☐ $15,000   ☐ $20,000

☐ $25,000   ☐ $50,000

☐ $75,000   ☐ $100,000

☐ Other $ _____

Multiple of Salary:

☐ 1 X Annual Salary to $ _____

☐ 2 X Annual Salary to $ _____

Dependent Life Benefit Amount:

☐ Spouse: $7,500; Child: $3,750

☐ Spouse: $4,000; Child: $2,000

☐ Spouse: $2,000; Child: $1,000

Note: Guarantee Issue / Plan Maximum Amnt

2–5 eligible employees: $25,000

6–19 eligible employees: $50,000

20–50 eligible employees: $100,000

Other Notes

The answers provided in this Product and Benefit Selection Form are accurate and complete to the best of my knowledge and belief, and the Insurer shall rely and act upon them accordingly.

This Product and Benefit Selection Form must accompany the Employer Application for Small Business.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature

Employer Signature	Title	Date

ⓤ UnitedHealthcare®