Product and Benefit Selection Form (1-100)

UnitedHealthcare

1. Group Name _____ Effective Date _____

2. Medical Plan Code(s)	Rx Plan Code(s)	Rates - EE Only	EE + Spouse	EE + Child	EE + Family

3a. Dental Plan Code(s)	Rates - EE Only	EE + Spouse	EE + Child	EE + Family

3b. Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

If yes, name of carrier _____

☐ Prior Carrier Invoice ☐ Copy of Current/Prior Benefits

4. Vision Plan Code	Rates - EE Only	EE + Spouse	EE + Child	EE + Family

5. Life Amount(s) in dollars

Employee* _____

Spouse _____

Child(ren) _____

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

*25K minimum life amount required to qualify for packaged savings for a life /medical sale

6. Supplemental Coverage(s)

Sup Life _____

STD _____

LTD _____

Accident** _____

Critical Illness** _____

**Limited Availability

7. Other Notes

8. Required Documents for Case Installation

- ☐ Employer Form
- ☐ Enrollment Spreadsheet (or Employee Applications if required)
- ☐ Sold proposal
- ☐ Copy of Binder Check
- ☐ Wage & Tax and Ownership Paperwork (Schedule C, K1 - if owners enrolling and not on W&T) 1-9 eligible only
- ☐ Participation Certification 10-50 eligible only
- ☐ Billing Agreement (51+ only, if applicable)

Signature

Employer Signature	Title	Date

UHC Account Executive: _____