Texas Small Business

Groups with 2-50 Average Total Number of Employees (ATNE)

Product and Benefit Selection Form

UnitedHealthcare Multi-Choice®

Billing Type

☐ Paper billing ☐ Online only/e-Bill ☐ Electronic Funds Transfer

****Billing cycle – For 15th of the month effective date, please select 1st or 15th of the month billing cycle:** ☐ 1st ☐ 15th

PLEASE NOTE: **Please refer to the Health Plan Product Offering for a complete list of the Multi-choice packages available. Please indicate which package and the plans within the package that are being offered to employees. A group may offer multiple plans; however, they must be within the same package.**

Medical Plan

☐ **Package Number** _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code_____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

*If an HSA plan is selected, which bank will be used?

☐ OptumBank℠ Other _____

This form is not considered complete until the last page is signed and dated.

Dental Plan

☐ Plan Code_____ ☐ Not elected

☐ Plan Code_____ ☐ Not elected

Vision Plan

☐ Plan Code_____ ☐ Not elected

☐ Plan Code_____ ☐ Not elected

Basic Life Amount

Employee:

☐ Flat Amounts $_____ ☐ Not elected

☐ 1x Salary

☐ 2x Salary

Dependent:

☐ Spouse $_____ ☐ Not elected

☐ Child(ren) $ _____

Please indicate salary amount on enrollment form for each employee for multiple of salary life.

Supplemental Coverage

Life/AD&D $_____ STD/LTD $_____ (Indicate plan codes)

Life/AD&D $_____ STD/LTD $_____ (Indicate plan codes)

Life/AD&D $_____ STD/LTD $_____ (Indicate plan codes)

- Complete addendum to Employer Application for Supplemental Life and Disability Lines of Coverage.
- Life/AD&D applies to groups with over 10 eligibles; maximum amount is $100,000.
- Supplemental Life must be sold with Basic Life.
- Please indicate salary amount on enrollment form for each employee for disability and multiple of salary life.

Optional State Rider Selection

Please review the offers below and indicate your acceptance or rejection. **Additional premium will be charged for the additional benefits chosen.**

In Vitro Fertilization

A health benefit that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures. Benefits for in vitro fertilization procedures must be provided to the same extent as benefits provided for other pregnancy-related procedures under the plan. The coverage is required only if the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan; the fertilization or attempted fertilization of the patient's ocytes is made only with the sperm of the patient's spouse; the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with endometriosis, exposure in utero to diethylstilbestrol (DES), blockage of or surgical removal of one or both fallopian tubes, or oligospermia; the patient has been unable to attain a successful pregnancy through any less-costly applicable infertility treatments for which coverage is available under the group health benefit plan; and the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.

In Vitro Fertilization: ☐ Accept ☐ Reject

Texas plans only

Signature

TEXAS INSURANCE LAWS REQUIRE ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN TEXAS TO SMALL EMPLOYERS OF 2-50 (ATNE) EMPLOYEES INCLUDING A BASIC OR STANDARD HEALTH BENEFIT, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. 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.

Employer Signature	Group Name	Date Signed

UnitedHealthcare®