

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
<input type="checkbox"/> a. Primary		
<input type="checkbox"/> b. Spouse		
<input type="checkbox"/> c. Child		
<input type="checkbox"/> d. Child		
<input type="checkbox"/> e. Child		
<input type="checkbox"/> f. Child		
<input type="checkbox"/> 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 __ / __ / __ __	Base Premium Amount (includes taxes and fees) \$ _____
Copay Plans <input type="checkbox"/> Bronze Copay Select SM 1 <input type="checkbox"/> Bronze Copay Select SM 2 <input type="checkbox"/> Silver Copay Select SM 1 <input type="checkbox"/> Silver Copay Select SM 2 <input type="checkbox"/> Gold Copay Select SM 1 <input type="checkbox"/> Gold Copay Select SM 2 <input type="checkbox"/> Platinum Copay Select SM	<input type="checkbox"/> HSA Deposit + _____
HSA Plans <input type="checkbox"/> Bronze HSA 100® <input type="checkbox"/> Silver HSA 100®	Total Monthly Payment (Payable to UHCLIC) = \$ _____
Catastrophic Plan <input type="checkbox"/> Select Saver SM	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:

- Premium will be verified and may be adjusted up or down during the processing of your application.
- Checks will be deposited upon receipt.
- EFT (personal account only) and Credit Card payments will be collected upon approval of 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

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)					PA	
b. Spouse					PA	
c. Child					PA	
d. Child					PA	
e. Child					PA	
f. Child					PA	
g. Child					PA	

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

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

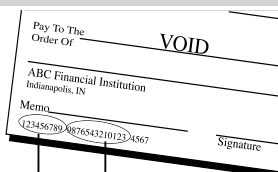
Electronic Funds Transfer (EFT) Authorization — Only if paying EFT

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-1013

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.

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