UnitedHealthcare Insurance Company
Administrative Office
9900 Bren Road East, Minnetonka, MN 55343

APPLICATION FOR GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, SHORT TERM DISABILITY, LONG TERM DISABILITY, ACCIDENT, and HOSPITAL INDEMNITY INSURANCE POLICY

A. GENERAL INFORMATION

1. FULL LEGAL NAME OF EMPLOYER: _____
2. STREET ADDRESS: (City, County, State, Zip Code) _____
3. FORM OF ORGANIZATION: ☐ Corporation ☐ Association ☐ Proprietorship ☐ Partnership
4. LIST ALL SUBSIDIARIES to be included: _____
5. EFFECTIVE DATE: _____
6. TAX ID NUMBER: _____ NATURE OF BUSINESS: _____
7. EMPLOYER PHONE NUMBER: _____ EMPLOYER FAX NUMBER: _____
   EMPLOYER E-MAIL ADDRESS _____

The Effective Date of the insurance is subject to approval of this application by UnitedHealthcare Insurance Company.

B. TYPE OF INSURANCE ELECTED

	Yes	No	No. of Eligible Employees	Percent of Employee Contribution
Basic Life Insurance				
Basic AD&D Insurance				
Supplemental Life Insurance				
Supplemental AD&D Insurance				
Dependent Basic Life Insurance				
Dependent Basic AD&D Insurance				
Dependent Supplemental Life Insurance				
Dependent Supplemental AD&D Insurance				
Short Term Disability				
Long Term Disability				
Accident Insurance				
Hospital Indemnity Insurance				

C. ADDITIONAL INFORMATION

1. Deposit submitted with application: _____ If the policy is issued, the deposit will apply towards the first month's premium.
2. Will all or part of this policy replace similar coverage? Yes ☐ No ☐
   If Yes, show Carrier(s), Policy Numbers and Termination Dates: _____

D. AGREEMENT

The Employer and UnitedHealthcare Insurance Company ("we", "us" or "our") agree that:

THE APPLICATION shall form the basis for and become part of any policy issued.

PREMIUM RATES shall: (1) be subject to all provisions in that policy; and (2) be binding on both Employer and us.

LIABILITY OF THE COMPANY: We will have no liability until this request has been approved at Our Administrative Office.

AUTHORITY OF AGENTS: No agent can change the terms of this request or any policy We issue. No agent can waive any of our rights or requirements or extend the time for any premium payments.

CHANGES AND CORRECTIONS: The acceptance of any policy issued on this request shall constitute ratification of any correction or amendment made by Us. Changes are an amendment to and form a part of the original request and any policy issued.

Dated at _____ this _____ day of _____

Dated at _____ this _____

Employer (full legal name) _____

Signature of Authorized Person _____ Print Name and Title _____

Licensed Resident Agent (signature) _____ P.O. Box Address (including zip _____

code)

Print Name of Agent and License Number

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in CALIFORNIA:
The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by us.

For residents of State XX: If group has employees in more than one state, add other state notice(s) here