

Product and Benefit Selection Form (1-100)



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

Yes

No

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: