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. 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:

ver060517