APPLICATION FOR DENTAL INSURANCE
UNITEDHEALTHCARE INSURANCE COMPANY
HARTFORD, CONNECTICUT 06103-0450

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Birth Date
☐ Male ☐ Female	Primary (You)	____/____/_____
☐ Male ☐ Female	Spouse	____/____/_____

Permanent Home Address (PO Box/PMB is not allowed)

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different from permanent home address)

Street (Include Apt.)	City	State	ZIP Code

Contact Information

Phone Number	Optional Email
( )	

Plan Selection

Plan Start Date
Your Plan will start on the first day of the month following receipt and approval of this Application Form and receipt of your first month's payment.
If you would like your Plan to start on a later date (the first day of a future month), please indicate the date: ____/_01_/_____

Plans *(Choose One)*	☐ DVH 500	☐ DVH 1000	☐ DVH 2000	☐ DVH 3000
	☐ DVH 500 PLUS	☐ DVH 1000 PLUS	☐ DVH 2000 PLUS	☐ DVH 3000 PLUS

Initial Payment

Estimated Monthly Premium **$** _____

Application Questions

		Yes	No
G1	Does any applicant intend to replace any existing dental coverage in force? If yes, Who:_____ Company Name:_____ If yes, Who:_____ Company Name:_____ If yes, Who:_____ Company Name:_____	☐	☐

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete. I understand and agree that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by UnitedHealthcare Insurance Company (UHIC) with this application.

(2) The primary applicant must be age 64 and 11 months or older on the plan effective date to be eligible for coverage.

(3) Incorrect or incomplete information in this application may result in voidance of coverage and claim denial.

(4) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy or policies that may be issued.

(5) If an application is approved, insurance will be effective:
   (a) The first day of the month following receipt and approval of this application and receipt of your first month's payment; or
   (b) The first day of a future month requested by you.

(6) The agent is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

(7) If UHIC rejects this application, under no circumstances will any benefits be payable. Receipt of payment by UHIC does not constitute approval of my application or create UHIC coverage.

(8) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(9) I acknowledge that applicant has access to/has received a Guide to Health Insurance for People with Medicare. The Guide to Health Insurance for People with Medicare is available at: https://stage.uhone.com/api/supplysystem/?Filename=Medicare-Medigap-guide.pdf

(10) **THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature Information

	Signature	Date Signed
Primary Applicant		

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- Other approved items and services

Before You Buy This Insurance

- Check the coverage in *all* health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

45574-X-37-0918

Producer Statement - Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____ X _____

Signature of Licensed Producer | Print Full Name

Producer Number

Payment Method - Select one below.

☐ EFT – Complete EFT Authorization below

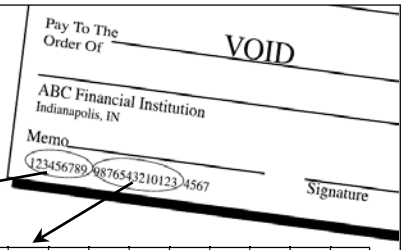
☐ Credit Card – Complete Credit Card Authorization below

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:

I (we) hereby authorize UnitedHealthcare 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

Only select a draft date between the 1st and 28th of the month.

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

☐ CREDIT CARD AUTHORIZATION – ONLY IF PAYING BY CREDIT CARD:

I authorize UnitedHealthcare Insurance Company to bill my MasterCard/Visa/American Express/Discover account.

Type of Card: ☐MasterCard ☐Visa ☐American Express ☐Discover

Exp Date _____ _____

Month | Year

Billing ZIP Code: _____ Card Number: _____

X _____

Signature of Authorized User

Charge On _____

Day

Only select a charge date between the 1st and 28th of the month.

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL AND/OR VISION INSURANCE
UNITEDHEALTHCARE INSURANCE COMPANY • 185 ASYLUM STREET • HARTFORD, CT 06103-0450
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, or information you have furnished, you intend to lapse or otherwise terminate existing dental and/or vision insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) Even though some of your present conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(3) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Failure to include all material information on an application may provide a basis for the company to deny any future claims and refund your premium as though your policy had never been in force.

After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

706I-U 0123

ELECTRONIC DELIVERY TERMS AND CONDITIONS

You will receive your Required Plan Communications electronically instead of receiving paper copies through the U.S. Mail. We will send you an email when a document is ready to view online.

Not all communications require permission before sending electronically. This Notice only applies when permission is required. Communications are based on the Plan(s) you have. You will get new types of communications as they become electronic. If there is not an electronic version, we will send by mail. Occasionally, in addition to electronic delivery, you may also receive a hard copy document.

You can request a free paper copy of documents that we are required to provide you by calling the phone number on your insurance ID card.

Your consent remains in effect until you withdraw it. You may withdraw your consent at any time and choose to begin receiving paper mailings by changing your delivery preferences on the member website or by calling the phone number on your insurance ID card. Changes may take up to seven business days to process.

It is your responsibility to notify us of any changes to your email address and your failure to do so may cause delayed communications. If attempts are made to deliver information to any email address you provide and the message is returned as undeliverable after several attempts and that email address is not updated by you, we will assume that you have withdrawn consent for electronic delivery and will begin sending the information to you in paper format. To ensure that you continue to receive emails from us, add the email "from" address to your email address book or safe list. To update your email address, go to your member website or you can call the phone number on your insurance ID card.

If you change plans or add a benefit, program, product or service, we will use the same contact information, when possible, to electronically deliver Required Plan Communications related to those services.

Requirements to access and retain information – in order to receive and retain electronic communications, you must have access to a computer or other device that is capable of mobile or internet access and complete your registration for the member website. This page contains documents in PDF format. PDF (Portable Document Format) files can be viewed with Adobe® Reader®. If you don't already have this viewer on your computer, download it free from the Adobe website (http://get.adobe.com/reader/).

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant's *(Your)* Email Address

_____
Parent/Guardian's *(if you are a minor)* Email Address

_____
Date

_____
Policy Number