PLEASE NOTE: THIS PRODUCT PROVIDES LIMITED BENEFITS. THIS IS NOT MAJOR MEDICAL OR COMPREHENSIVE HEALTH INSURANCE, AND DOES NOT PROVIDE THE MANDATED COVERAGE NECESSARY TO AVOID PENALTY UNDER THE AFFORDABLE CARE ACT.

UNITEDHEALTHCARE LIFE INSURANCE COMPANY
Application for Accident Insurance

SECTION 1

Applicant(s) Information - Must Be Completed by the Applicant(s)

Please Print In Black Ink

Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Birth Date	Age
☐ Male ☐ Female	Primary (You)		
☐ Male ☐ Female	Spouse		
☐ Male ☐ Female	Child 1		
☐ Male ☐ Female	Child 2		
☐ Male ☐ Female	Child 3		
☐ Male ☐ Female	Child 4		
☐ Male ☐ Female	Child 5		

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ☐

Mailing Address

Street (Include Apt.)

City State ZIP

Phone Numbers ( ) ( ) ( )

Home Work (optional) Cell (optional) Email Address

A physical address is required if different than your mailing address. PO Boxes are not accepted as a physical address.

Physical Address

Street (Include Apt.)

City State ZIP

Payor
(If not You) Name Email Address

Street City State ZIP

Your Beneficiary: ______________________________ You will be the beneficiary for your spouse.

Name Relationship Age

Your Occupation: ______________________________

Requested Effective Date: _____/_____/_____

SECTION 2

Plan Choices

☐ **Accident SafeGuard℠ Plan A**
☐ **Accident SafeGuard℠ Plan B**
☐ **Accident SafeGuard℠ Plan C**

Total Monthly Premium $ __________

If Quarterly, Total Monthly Premium x 3 $ __________

SECTION 3

Underwriting Questions – Must be completed

Question		If Yes, Who?
1. Does any applicant have or is any applicant currently applying for major medical insurance or any accident-only insurance?	☐ Yes ☐ No	

If yes, Who: ____________ Company Name: ____________ Policy Number: ____________
If yes, Who: ____________ Company Name: ____________ Policy Number: ____________
If yes, Who: ____________ Company Name: ____________ Policy Number: ____________

Question		If Yes, Who?
2. Does any applicant intend to replace any existing coverage in force?	☐ Yes ☐ No	

If yes, Who: ____________ Company Name: ____________ Policy Number: ____________
If yes, Who: ____________ Company Name: ____________ Policy Number: ____________
If yes, Who: ____________ Company Name: ____________ Policy Number: ____________

Question		If Yes, Who?
3. Is any applicant employed in any of the following occupations:		
a. Transportation of hazardous materials; b. Demolition or any handling or transport of explosives; c. Logging industry (any outdoor occupation in this industry); d. Any offshore occupation in fishing, salvage, oil, or natural gas industry; e. Professional diving or diving attendants; f. Stunt, carnival or circus workers, or professional rodeo performers; g. Underground mining workers; h. Structural iron or steel workers (greater than 2 stories); i. Foreign travel required for missionary, diplomats, journalists, archaeologist, geologist, foreign, or volunteer aid worker?	☐ Yes ☐ No	
4. During the past 24 months, did any applicant engage in, or in the next 12 months, does any applicant plan to engage in, any of the following activities:		
a. Driving a motorcycle; b. Motorized racing (includes drivers, pit crew, owners, mechanics, speed test, or stunt show); c. Competitive skiing, snowboarding, biking, or skateboarding; d. Sky diving, parachute jumping, hang gliding, or parakiting; e. Skin or scuba diving (deeper than 60 feet and more than once per year); f. Rock/Mountain climbing; g. Student pilot (airplane, helicopter, glider, ultra-light); h. Pilot or crew member of a non-commercial aircraft (airplane, helicopter, glider, or hot air balloon)?	☐ Yes ☐ No	
5. During the past 5 years, has any applicant:		
a. Been convicted of a felony?	☐ Yes ☐ No	
b. Been convicted of driving under the influence of drugs or alcohol?	☐ Yes ☐ No	
c. Been convicted of reckless driving or had three or more moving violations?	☐ Yes ☐ No	
d. Had his/her driver's license suspended or revoked?	☐ Yes ☐ No	
6. During the past 5 years, has any applicant been treated by a physician or advised by a physician to seek treatment for drug or alcohol abuse or addiction?	☐ Yes ☐ No	

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box. ☐

SECTION 4

General Statement of Understanding – Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded to the best of my knowledge and belief. This Statement of Understanding section will become part of the application. I understand and agree that:

(1) This application and the initial payment do not give me immediate coverage.

(2) I should not terminate existing coverage until I have accepted the UnitedHealthcare Life Insurance Company (UHCLIC) coverage.

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

(4) This completed application, and any supplements or amendments, will be a part of any policy or policies, if issued.

(5) The producer may only submit the application and initial payment, and may not promise me coverage, modify UHCLIC's underwriting policy or terms of coverage, or change or waive any right or requirement.

(6) The producer may receive copies of any correspondence about my medical history when correspondence is required.

(7) I must notify UHCLIC of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.

(8) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all applicants.

(9) If UHCLIC rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by UHCLIC does not constitute approval of my application or create UHCLIC coverage.

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

(11) **THIS PRODUCT PROVIDES LIMITED BENEFITS. THIS IS NOT MAJOR MEDICAL OR COMPREHENSIVE HEALTH INSURANCE, AND DOES NOT PROVIDE THE MANDATED COVERAGE NECESSARY TO AVOID PENALTY UNDER THE AFFORDABLE CARE ACT.**

X ______________________________ Proposed Insured's Signature

X ______________________________ Date signed and read application and product brochure

X ______________________________ Spouse's Signature

X ______________________________ Date signed and read application and product brochure

Payment

Initial Payment Method With Application – Select One Below

☐ **EFT** — Complete EFT Authorization below (EFT is only available with Monthly Initial Payment)
☐ **Credit Card** — Complete Credit Card Authorization below
☐ **Check** — Made payable to UnitedHealthcare Life Insurance Company

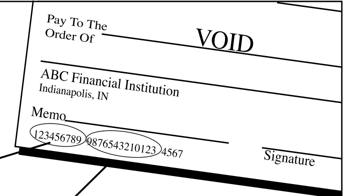
Ongoing Payments – Select One Below

Monthly: ☐ EFT (complete EFT Authorization below) **Quarterly**: ☐ Direct Bill

Electronic Funds Transfer (EFT) and Credit Card payments will be collected on the date we issue coverage, or the effective date of the policy, whichever is later. If Initial Payment is EFT, Ongoing Payment must be EFT.

If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt.

☐ **ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY 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
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 Email Address

☐ **CREDIT CARD AUTHORIZATION – INITIAL PAYMENT ONLY:**

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.

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.

Final Authorizations

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 Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X ______________________________ X ______________________________

Signature of Licensed Producer | Print Full Name

Producer Number

Authorization to Obtain and Disclose Nonmedical Information

I authorize UnitedHealthcare Life Insurance Company's (UHCLIC) Insurance Administration and Claims departments to obtain information that they need to underwrite or verify my application for insurance. Any employer, insurance company, government agency, consumer-reporting agency, or MIB, Inc., formerly known as Medical Information Bureau (MIB) 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 UHCLIC's Insurance Administration and Claims departments.

UHCLIC may also release this information about my family or me to the MIB or any member company for the purposes described in UHCLIC's Notice of Information Practices.

I (we) have received UHCLIC'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 UHCLIC. I (we) may request revocation of this authorization by writing to UHCLIC, as explained in UHCLIC's Notice of Information Practices. UHCLIC 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.

I have read the above: Authorization to Obtain and Disclose Nonmedical Information.

Signed X ___/___/___ X ______________________________

Date | Signature of Primary Applicant (You)

X ______________________________

Signature of Spouse (If to be covered)

SGADNI-UL-1013

Authorization to Obtain and Disclose Health Information

I authorize UnitedHealthcare Life Insurance Company's (UHCLIC) Insurance Administration and Claims departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, pharmacy benefit manager, consumer-reporting agency, MIB, Inc., formerly known as Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to UHCLIC's Insurance Administration and Claims departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

UHCLIC may release this information about my family or me to the MIB or any member company for the purposes described in UHCLIC's Notice of Information Practices.

I (we) have received UHCLIC'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 UHCLIC;
- I (we) may request revocation of this authorization as described in UHCLIC's Notice of Information Practices;
- UHCLIC 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 regulating health insurers.

I have retained a copy of this authorization.

SGADHI-UL-1013

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X ___/___/___ X ______________________________

Date | Signature of Primary Applicant (You)

X ______________________________

Signature of Spouse (If to be covered)