CONNECTICUT

APPLICATION FOR DENTAL/VISION INSURANCE
UNITEDHEALTHCARE LIFE INSURANCE COMPANY — GREEN BAY, WISCONSIN

PLEASE PRINT IN BLUE INK

APPLICANT(S) INFORMATION

PROPOSED INSURED: _____ ☐ Male ☐ Female

First Name | Middle Initial | Last Name | Birth Date: Month | Day | Year | Age | Gender

Mailing Address:

Street (Include Apt.)

City | State | ZIP

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

Phone Numbers: (____) Home (____) Other | Best number and times to call | Email Address

DEPENDENTS: List below any dependents to be covered under the policy.

Name (Last, First, M.I.)	Relationship	Birth Date	Gender
	Spouse	/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F

PAYOR: _____

(If not You): Name | Email Address

Street | City | State | ZIP

	Yes	No
1. Are you or any dependent intending to replace current in force dental or vision, (if applicable) insurance?	☐	☐

REQUESTED EFFECTIVE DATE: _____/_____/_____ *(See Statement of Understanding section.)*

Plan Choices: ☐ UnitedHealthcare Dental Premier Elite℠ ☐ UnitedHealthcare Dental Premier Choice℠
☐ UnitedHealthcare Dental Essential℠ ☐ UnitedHealthcare Dental Essential Preferred℠

OPTIONAL: ☐ UnitedHealthcare Vision

Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual

Payment Options: **Initial Payment with Application**: ☐ Check ☐ EFT ☐ Credit Card

Ongoing Payments: ☐ Monthly EFT ☐ Direct Bill *(quarterly, semiannual and annual only)* ☐ List Bill *(include forms; $25 monthly admin. fee per list bill group)*

Initial Premium for Mode Chosen* $_____

*The amount charged to your credit card will be the total amount for the payment mode chosen (Monthly, Quarterly, Semiannual, or Annual).

May 20 2015 11:55:01 am

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by UnitedHealthcare Life Insurance Company with this application; (b) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (c) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by UnitedHealthcare Life Insurance Company. I understand that, for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by UnitedHealthcare Life Insurance Company. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X _____ X _____ X _____

Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child | State where you signed this application | Date you signed and read application

X _____ X _____

Signature of Licensed Broker | Broker Printed Name

Broker Number

IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by UnitedHealthcare Life Insurance Company more than 15 days after the date signed. Altered applications will not be accepted.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

UNITEDHEALTHCARE LIFE INSURANCE COMPANY: 3100 AMS BOULEVARD, PO BOX 19032 • GREEN BAY, WI 54307-9032

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 insurance and replace it with a policy to be issued by UnitedHealthcare Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. 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.
2. 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 to 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.

Also, if you are issued coverage, carefully check the application again and write to UnitedHealthcare Life Insurance Company at the address shown at the top of this notice within 10 days if any information is not correct and complete.

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

_____ _____

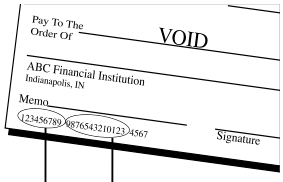
Date | Applicant's Signature

722D-UL **UnitedHealthcare Life Insurance Company's Copy** 0314

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. _____

Acct No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____

Day | Date Signed

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 _____

EFT-UL-1013

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize UnitedHealthcare Life Insurance Company to bill my American Express/MasterCard/Visa account for the Total Premium for Mode Chosen.*

Type of Card: ☐ MasterCard ☐ Visa ☐ American Express Exp. Date: _____ _____

Month | Year

ZIP Code: _____

Card Number: _____

X _____

Signature of Authorized User

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

CCDEN-UL-1013

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

UNITEDHEALTHCARE LIFE INSURANCE COMPANY: 3100 AMS BOULEVARD, PO BOX 19032 • GREEN BAY, WI 54307-9032

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 insurance and replace it with a policy to be issued by UnitedHealthcare Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. 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.
2. 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 to 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.

Also, if you are issued coverage, carefully check the application again and write to UnitedHealthcare Life Insurance Company at the address shown at the top of this notice within 10 days if any information is not correct and complete.

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

Date

Applicant's Signature

722D-UL **Applicant's Copy** 0314

Mail completed application and initial premium to:
UnitedHealthcare Life Insurance Company
PO Box 31370
Salt Lake City, UT 84131-0370

May 20 2015 11:55:01 am