Enrollment Application/Change/Cancellation Request

UnitedHealthcare
A UnitedHealth Group Company

☐ UnitedHealthcare Insurance Company
☐ UnitedHealthcare Insurance Company of Illinois
☐ UnitedHealthcare of Illinois, Inc.
☐ UnitedHealthcare Insurance Company of the River Valley
☐ UnitedHealthcare Plan of the River Valley, Inc.

☐ **Enroll** ☐ **Cancel** ☐ **Change** | ☐ **Address Change** ☐ **Name Change** **Date of Change** ___/___/___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____ Dental _____ Life _____ UnitedHealthcare Overture Package _____ (A-S)	Medical _____ Vision _____ Dental _____ Life _____	Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____ Dep. Life _____ Critical Illness _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage/Civil Union ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date _____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe) _____

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

A. Employee Information

Employer Position _____ Phone Number _____

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex ☐ M ☐ F	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*

Marital Status	Race – Check all that apply (Optional)**
☐ Single ☐ Married Spouse ☐ Divorced ☐ Civil Union Spouse ☐ Widowed ☐ Domestic Partner	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage provided by "UnitedHealthcare and Affiliates"
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company, Unimerica Insurance Company, or Dental Benefit Providers of Illinois, Inc.
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision Coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name / First Name / MI / Social Security Number	Sex	Relationship**	Birthdate	Physician*(First and Last Name) / Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change		M F	Spouse /Domestic Partner		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)* ** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse /Domestic Partner	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address

Relationship

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

~~I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for~~ the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Beneficiary Form
Group Term Life Insurance

UnitedHealthcare®

Important Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company			
Policyholder:			
Individual Covered Person	SSN# and DOB:	Phone#	
Street Address (please include apartment # as applicable)	City	State	Zip

THE BENEFICIARY FOR THE POLICY SHALL BE:

Primary Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries

Contingent Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

Insured's Signature: _____

Insured's Printed Name: _____

Date: _____

In case I name more than one person in a group of beneficiaries, whether as the Primary beneficiaries or as the Contingent beneficiaries, then unless I otherwise direct in writing above, each designated beneficiary in a group shall share equally in the amount to be paid under the covering policy. In the event any designated beneficiary (ies) in a group predeceases me, then the remaining beneficiary (ies) in that group of beneficiaries shall share equally in the life insurance proceeds to be paid under the policy.

United Healthcare

Vision Benefit Card

Winning Wheels, Inc

Copays

Exam(s)	$10.00		
Eyeglasses	$25.00	Retinal Screening	$ 39.00
Contacts	$25.00		

Powered by UnitedHealthcare Vision Network

United Healthcare

myuhcvision.com

Customer Service & Provider Locator: (800) 638-3120

TDD for Hearing Impaired: (877) 735-2929

To print a personalized ID card, please log on to our website and select 'Group/Plan' then select 'Print ID card' from the member benefits page.

Colonial Life

Winning Wheels
Open Enrollment 2022

Everyone's benefit needs are different. That's why it's important to choose the benefits that are right for your personal situation. Complete this page and bring it to your personal, 1-to-1 benefits counseling session. At the session, you'll learn how these products fit into your overall benefits package and how they can help protect what you've worked so hard to build.

☐ **Accident-** Helps offset unexpected medical expenses, such as emergency room fees, deductibles and co-payments that can result from fracture, dislocations, or other covered accidental injury.

☐ **Short Term Disability** – Helps replace a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.

☐ **Critical Illness-** Supplements your major medical coverage by providing a lump-sum benefit you can use to pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy.

☐ **Medical Bridge-** Provides a lump-sum benefit for a covered hospital confinement or a covered outpatient surgery to help with co-payments and deductibles that are not covered by most major medical plans.

☐ **Life Insurance-** Enables you to tailor coverage for our individual needs and helps provide financial security for your family members.

Use this sheet as a reference point for your meeting with the benefits counselor.

Please scan the QR code below or call 217-408-4728 to schedule your meeting with the benefits counselor. If you have any questions, please feel to reach out to vickioffice.lynn@coloniallifesales

All meetings with the Benefits Counselor will be done via phone/internet.

Illinois Secure Choice
Retirement Savings Program

EMPLOYEE OPT OUT FORM

Illinois Secure Choice is a completely voluntary program. You can opt out at any time online, by phone, or by completing this form. If you do not opt out your employer will send payroll contributions to your Illinois Secure Choice account. Amounts you save in this account are always your money. Your account is in your control and goes with you from job to job in accordance with the Illinois Secure Choice Program terms. Every little bit you save now can potentially make a difference in retirement. To opt out of payroll contributions to Illinois Secure Choice for more than one employer you must submit a separate form for each employer.

Completed forms should be mailed back to Illinois Secure Choice.
Illinois Secure Choice
PO Box 56000
Boston, MA 02205-6000

Overnight Address:
Illinois Secure Choice
95 Wells Avenue, Suite 155
Newton, MA 02459

You may also opt out online or by phone.
855-650-6914
8 a.m. to 8 p.m. CT, Monday through Friday

saver.ilsecurechoice.com

1. EMPLOYEE INFORMATION *(All fields required)*

To verify your information, please provide either the last four digits of your Social Security Number/Taxpayer Identification Number, or your access code and date of birth. The access code can be found in the email or letter you received from Illinois Secure Choice.

Legal Name *(First)* *(M.I.)*

Legal Name *(Last)*

Address

City State Zip Code

Telephone Number *(In case we have a question)*

Last Four Digits of Social Security Number or Taxpayer Identification Number

Access Code

Birth Date *(mm/dd/yyyy)*

2. OPT OUT REASON

- ☐ I don't qualify for a Roth IRA due to my income
- ☐ I would prefer a Traditional IRA
- ☐ I have my own retirement plan
- ☐ I can't afford to save at this time
- ☐ I don't trust the financial markets
- ☐ I'm not satisfied with the investment options
- ☐ I'm not interested in contributing through this employer
- ☐ Other

3. EMPLOYER INFORMATION

Employer Name

4. SIGNATURE

I do not wish to participate in the Illinois Secure Choice Program at this time. I understand that I can change my mind at any time and begin participating in Illinois Secure Choice at a later date, subject to and in accordance with the terms of the Illinois Secure Choice Program. If I decide to opt back in, I can contact Illinois Secure Choice.

Signature of Employee

Date *(mm/dd/yyyy)*

Illinois Secure Choice
Retirement Savings Program

IRA ACCOUNT MAINTENANCE FORM

Complete this form to change your name, permanent and/or mailing address, phone number, email address, contribution rate, annual increase, or bank information. You may also update this information online by logging into your account at saver.ilsecurechoice.com.

If you are changing your legal name, your signature with your old name and your signature with your new name are required to be Medallion Signature Guaranteed in Section 3 by an authorized officer of a bank, broker, or other qualified financial institution. In place of a Medallion Signature Guarantee, you have the option to submit a signed letter of instruction with supporting legal documentation (i.e. marriage certificate, court order, divorce documentation) for this change.

The updates/changes on this form override all previous elections for this IRA. Contact the Client Service team if you need assistance completing this form.

Completed forms should be mailed to: Illinois Secure Choice
PO Box 56000
Boston, MA 02205-6000

Overnight Address: Illinois Secure Choice
95 Wells Avenue, Suite 155
Newton, MA 02459

855-650-6914
8 a.m. to 8 p.m. CT, Monday through Friday

saver.ilsecurechoice.com

1. IRA OWNER INFORMATION *(All fields required)*

If you are updating your information, enter the information that is currently on file in this section and the new information in Section 3.

Account Number

IRA Owner Legal Name *(First)* *(If you are changing your name, enter the name you have on file in this section.)* *(M.I.)*

IRA Owner Legal Name *(Last)*

–

Telephone Number *(In case we have a question about your Account. If you are updating your phone number, enter the number you have on file in this section and the new number in Section 3.)*

Employer Name *(If you contribute through more than one employer and want to change your contribution rate or automatic annual increase election, you must submit a separate form for each employer.)*

2. ACCOUNT UPDATES OR CHANGES

Check the box(es) to indicate which section(s) you plan to update or change.

☐ **IRA Owner Information** – Section 3

☐ **Bank Information** – Section 4

☐ **Contribution Rate** – Section 5

☐ **Automatic Annual Increase** – Section 6

3. UPDATE IRA OWNER INFORMATION

If you are changing your name and/or contact information, provide the new information exactly as you would like it to appear on your Illinois Secure Choice IRA.

If you are changing your name, you must also provide a Medallion Signature Guarantee below or legal document(s) verifying the name change.

IRA Owner Legal Name *(First)* *(M.I.)*

IRA Owner Legal Name *(Last)*

Email Address

Physical Address *(We cannot accept a PO Box)*

City State Zip Code

Mailing Address if different from above *(This address will be used as the address of record and for all mailings)*

City State Zip Code

Telephone Number

Medallion Signature Guarantee — REQUIRED FOR NAME CHANGES TO THE ACCOUNT OWNER OF AN EXISTING ACCOUNT ONLY

- You must provide the following information as underwritten certification that the new signature is genuine.
- You can obtain a Medallion Signature Guarantee from an authorized officer of a bank, broker, or other qualified financial institution. A notary public cannot provide a Medallion Signature Guarantee, nor can you guarantee your own signature.
- **Do not sign below until you are in the presence of the authorized officer providing the signature guarantee.**

By signing here I certify that the information provided herein is true and complete in all respects.

Former Signature of Account Owner *(For name change only)*

Current Signature of Account Owner

Signature of Guarantor

Authorized Officer to Place Stamp Here

Title

Name of Institution

Date *(mm/dd/yyyy)*

4. UPDATE BANK INFORMATION

Important: *By signing this form, you agree and confirm that your ACH transaction will not involve the branches or offices of a bank or other financial services company located outside the territorial jurisdiction of the United States.*

☐ Add ☐ Delete Bank Information Indicated Below ☐ Delete All Current Bank Information and Add New Bank Information Below

Financial Organization Name

Financial Organization Routing Number

Financial Organization Account Number

ACCOUNT TYPE *(Select one)*

☐ Checking ☐ Savings

Note: *The routing number is usually located on the bottom left corner of your checks. You can also ask your financial organization for the routing number.*

☐ Add ☐ Delete Bank Information Indicated Below ☐ Delete All Current Bank Information and Add New Bank Information Below

Name

Financial Organization Routing Number

Financial Organization Account Number

ACCOUNT TYPE *(Select one)*

☐ Checking ☐ Savings

Note: *The routing number is usually located on the bottom left corner of your checks. You can also ask your financial organization for the routing number.*

5. UPDATE CONTRIBUTION RATE

If you wish to change your contribution rate, enter the percentage of your pay check you wish to contribute as a whole number. ***Note:*** *Your contributions to all of your Roth IRA are limited to $5,500 ($6,500 if 50 or older) for 2018 depending on your income. See IRS Publication 590A for more information.*

New Contribution Rate ☐☐☐ %

6. AUTOMATIC ANNUAL INCREASE

Contributions for accounts open at least 180 days will automatically increase by 1% on January 1 of each year, with the first increase scheduled for January 1, 2019.

☐ I wish to have my contribution rate automatically increased by 1% each year until it reaches 10%.

☐ I DO NOT wish to have my contribution rate automatically increased each year.

7. SIGNATURE

I certify that I am the account owner and verify the information above is accurate. I assume responsibility for any consequences that may result from these changes and I agree that Illinois Secure Choice, the custodian, or the program administrator are not responsible for any consequences that may arise from executing the changes outlined in this form.

Signature of IRA Owner

☐☐–☐☐–☐☐☐☐

Date *(mm/dd/yyyy)*