Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail: (must submit by mail if enclosing a check or money order)

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!
I hereby enroll for membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues, I understand that: (a) I will be entitled to FACT’s benefits; (b) these benefits may change from time to time; (c) some benefits may have a delayed effective date; (d) my membership will become effective on the day this enrollment form is dated and signed; (e) I am eligible to apply for association group insurance; and (f) I authorize the release of the following information to FACT: my name, address, date of birth, certificate and phone numbers, application date, and email address listed on the UnitedHealthcare Life Insurance Company Application for Insurance. NOTE: Accident Insurance is included in your FACT membership and you will have an opportunity to name your beneficiary(ies) by mail or on the FACT website.

SECTION 1 UNITEDHEALTHCARE LIFE INSURANCE COMPANY — Application for Insurance

1. REASON FOR APPLICATION:

☐ New Application  ☐ Add a dependent  ID Number

2. PRIMARY APPLICANT’S INFORMATION:

   (for additions)

   a. Name (Last, First, M.I.): ________________________________

   b. Mailing Address

      Street (Include Apt.) _______________________________________

      City __________________________________ State ______ ZIP ____

   c. 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 ____

   d. County of Residence ______________________

   e. Phone Numbers

      ( ) Home ( ) Other Best number and time to call

      Email Address ____________________________________________

   f. Payor

      (If not You) Name ________________________________________

      Email Address ____________________________________________

      Street __________________________________ City ______ State ______ ZIP ____

   g. Marital Status: ☐ Married  ☐ Single

3. APPLICANTS FOR COVERAGE:

Please list only those persons needing coverage.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Name (Last, First, M.I.)</th>
<th>Social Security No.</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male</td>
<td>a. Primary (You)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Male</td>
<td>b. Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Male</td>
<td>c. Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Male</td>
<td>d. Child</td>
<td></td>
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<tr>
<td>☐ Male</td>
<td>e. Child</td>
<td></td>
<td></td>
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<tr>
<td>☐ Male</td>
<td>f. Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Male</td>
<td>g. Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ☐
4. Is any applicant not a United States citizen or national?  ☐ YES ☐ NO

(If yes, indicate who below and provide the requested information for that person.)

<table>
<thead>
<tr>
<th>Applicant (same as in Question 3)</th>
<th>Does this person have eligible immigration status?</th>
<th>Document Type</th>
<th>ID Number</th>
<th>Has this person lived in the U.S. since 1996?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>b. Spouse</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>c. Child</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>d. Child</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>e. Child</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>f. Child</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>g. Child</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

5. In the last 6 months, has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) 4 or more times per week on average, excluding religious or ceremonial uses?  ☐ YES ☐ NO

(If yes, indicate who.)


**SECTION 2**

Product Selection & Billing (or attach a health insurance quote). Complete for new applications only.

- FACT Membership Dues: $ ____________
- Base Premium Amount (includes taxes and fees): + ____________

**OPTIONAL BENEFITS** — See current brochure and inserts for availability

- Supplemental Accident: + ____________ Optional
- Accidental Death (Primary): + ____________ Optional
- Accidental Death (Spouse): + ____________ Optional
- UnitedHealthcare Vision (for adults): + ____________ Optional
- HSA Deposit: + ____________

**Total Monthly Payment** (Payable to FACT) = $ ____________

If Quarterly, Total Monthly Payment x 3 (Payable to FACT) = $ ____________

6. Payment

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

**Ongoing Payments:** Monthly ☐ EFT ☐ Direct Bill

☐ Employer Payor Agreement (include forms; a fee if applicable)

Quarterly ☐ Direct Bill

**IMPORTANT:**
- Premium will be verified and may be adjusted up or down during the processing of your application.
- Checks will be deposited upon receipt.
- EFT (personal account only) and Credit Card payments will be collected upon approval of application.
SECTION 3
Special Enrollment
Complete only if applying outside the open enrollment time frame. You must provide written proof of eligibility for any of the reasons marked in question 7. Submit copies of documents supporting the occurrence of the event(s).

7. You may be eligible for health insurance coverage under Special Enrollment Periods if at least one of the following events occurred in the last 60 days: (Mark all that may apply, indicate to whom they apply, and answer the corresponding questions.)

☐ a. Loss of health insurance. Which applicant(s)? _________________________________________________________________
   i. Did the applicant lose health insurance because of not paying premium? ........................................................... ☐ YES ☐ NO
   ii. When did the applicant lose health insurance? (MM/DD/YY) / / 
   iii. Type of insurance coverage lost:
       ☐ Group — Provide employer’s information

   Employer’s Name

   Street
   City
   State
   ZIP
   Telephone Number

   Individual
   COBRA
   Effective date of COBRA / / Date COBRA Terminated / /
   Short Term
   Medicaid
   ☐ Other (please specify) __________________________________________________________

☐ b. Married. Which applicant(s)? __________________________________________________________
   i. When did the applicant get married? (MM/DD/YY) / / 

☐ c. Birth, adoption, or placement for adoption. Which applicant(s)? _______________________________
   i. When was the applicant born, adopted, or placed for adoption? (MM/DD/YY) / / 

☐ d. Released from incarceration (jail or prison). Which applicant(s)? _______________________________
   i. When was the applicant released? (MM/DD/YY) / / 

☐ e. Moved to a different state. Which applicant(s)? _______________________________________________
   i. When did the applicant move? (MM/DD/YY) / / 
   ii. What is the address the applicant moved from?

   Street
   City
   State
   ZIP

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Optional Accidental Death Insurance Coverage (Not available for children.)
Complete this section only if applying for optional underwritten accidental death insurance coverage for the primary applicant and/or spouse.

8. In the last 2 years, did any applicant engage in, or in the next 12 months, does any applicant plan to engage in, any of the avocations listed below:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Applicant</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Motorized racing (automobile, motorcycle, water-craft, snowmobile, etc.)?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Competitive skiing or snowboarding?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Skydiving (more than once per year)?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Skin or scuba diving (deeper than 60 feet and more than once per year)?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Hang gliding?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Student pilot (airplane, helicopter, glider, ultra-light)?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Pilot or crew member of an aircraft (commercial, private Cessna, hot air balloon)?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Driving a motorcycle?</td>
<td>☐ ☐</td>
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<td></td>
</tr>
</tbody>
</table>

9. In the last 5 years, was any applicant convicted of a felony, DUI, or had his/her driver's license suspended or revoked?

For each Yes answer in Questions 8 and 9, provide the applicant's name. If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box.

Question Number _____ Applicant ____________________________ Question Number _____ Applicant ____________________________
Question Number _____ Applicant ____________________________ Question Number _____ Applicant ____________________________
Question Number _____ Applicant ____________________________ Question Number _____ Applicant ____________________________
Question Number _____ Applicant ____________________________ Question Number _____ Applicant ____________________________

This policy is primarily governed by the laws of Arkansas. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SECTION 5
Statment 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.

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 coverage.
3. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.
4. This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.
5. The broker may only submit the application and initial payment, and may not promise me coverage, modify UnitedHealthcare Life’s underwriting policy or terms of coverage, or change or waive any right or requirement.
6. 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 listed dependents.

X _______________________ / / Primary Applicant (You) Date

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

X _______________________ Spouse (if to be covered)

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SECTION 6

Broker 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 ______________________________________________________
Signature of Licensed Broker

X ______________________________________________________
Print Full Name

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

X ______________________________________________________
Spouse (if to be covered)

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 ______________________________________________________
Primary Applicant (You) Date

X ______________________________________________________
Countersigned by Licensed Resident Agent

Primary Care Physician Selection: Please select a Primary Care Physician (PCP) from our network who is in your state of residence. If no PCP is listed, we will assign one to you. See our Physician Listing at UHCindividual.com/doctor.

<table>
<thead>
<tr>
<th>Physician's Name</th>
<th>Phone Number</th>
<th>Office Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary (You)</td>
<td></td>
<td></td>
<td></td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td>b. Spouse</td>
<td></td>
<td></td>
<td></td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td>c. Child</td>
<td></td>
<td></td>
<td></td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td>d. Child</td>
<td></td>
<td></td>
<td></td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td>e. Child</td>
<td></td>
<td></td>
<td></td>
<td>FL</td>
<td></td>
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<tr>
<td>f. Child</td>
<td></td>
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<td></td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td>g. Child</td>
<td></td>
<td></td>
<td></td>
<td>FL</td>
<td></td>
</tr>
</tbody>
</table>

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

Authorization to Obtain and Disclose Nonmedical Information

I authorize UnitedHealthcare Life Insurance Company to obtain information that they need to verify my application for insurance. Any employer, insurance company, government agency, or consumer-reporting agency 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 UnitedHealthcare Life Insurance Company.

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

X ______________________________________________________
Primary Applicant (You) Date

X ______________________________________________________
Spouse (if to be covered)

William C. Stapleton
Print Full Name

Broker 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.
Health Savings Account (HSA) application — Only if opening an HSA with Optum Bank

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with Optum Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened and governed by Optum Bank’s Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with Optum Bank’s Privacy Policy and Schedule of Fees.
- I authorize Optum Bank to provide information about my HSA, including my account number, to UnitedHealthcare Life Insurance Company, and those acting on behalf of UnitedHealthcare Life Insurance Company or Optum Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that UnitedHealthcare Life Insurance Company and all others acting on behalf of UnitedHealthcare Life Insurance Company, may provide information on my behalf to establish and maintain my HSA and authorize UnitedHealthcare Life Insurance Company and its designee to take such action deemed necessary and appropriate by UnitedHealthcare Life Insurance Company to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Optum Bank if I wish to have statements mailed to my home address.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User debit card, I hereby request Optum Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I authorize Optum Bank to share information about my HSA with the Authorized User named, and to allow any account transactions made by such Authorized User.
- I certify that the information provided in this application is true and complete.

Signature of Primary Applicant

Primary Applicant's Social Security No.

Applicant's Spouse Social Security No.

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver’s license or other identifying documents.

REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)

Authorized User’s First Name Middle Initial

Authorized User’s Last Name

Authorized User’s Date of Birth

Authorized User’s Social Security No.

Electronic Funds Transfer (EFT) Authorization — Only if paying EFT

I (we) hereby authorize FACT or 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 __________________________ 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 __________________________

Initial Payment Credit Card Authorization

I authorize FACT or 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 plus any one-time costs.

Type of Card: □ MasterCard □ Visa □ American Express

Exp. Date: ____________

Month Year

Card Number: ____________

Billing ZIP Code: ____________

Signature of Authorized User

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