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!

FACT Membership Enrollment Form — Missouri

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.

Member's Signature X_____ Date X _____

FACT ENFO 1013 If you wish to apply for association group health insurance, please complete the application below.

SECTION 1 UNITEDHEALTHCARE LIFE INSURANCE COMPANY — Application for Insurance

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

Please Print In Black Ink

1. REASON FOR APPLICATION:

☐ New Application ☐ Add a dependent ID Number _____ (for additions)

2. PRIMARY APPLICANT'S INFORMATION:

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.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date
☐ Male ☐ Female	a. Primary (You)		
☐ Male ☐ Female	b. Spouse		
☐ Male ☐ Female	c. Child		
☐ Male ☐ Female	d. Child		
☐ Male ☐ Female	e. Child		
☐ Male ☐ Female	f. Child		
☐ Male ☐ Female	g. Child		

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.)

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

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.)

☐ a. Primary ☐ b. Spouse ☐ c. Child ☐ d. Child ☐ e. Child ☐ f. Child ☐ g. Child

SECTION 2

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

Effective Date
__ __/__ __/__ __ __ __

Copay Plans
☐ Bronze Copay Select℠
☐ Silver Copay Select℠ 1
☐ Silver Copay Select℠ 2
☐ Silver Copay Select℠ 3
☐ Gold Copay Select℠ 1
☐ Gold Copay Select℠ 2

HSA Plans
☐ Bronze HSA 100®
☐ Silver HSA 100®

Catastrophic Plan
☐ Select Saver℠
(Must provide a copy of a Certificate of Exemption for each applicant who is age 30 or older.)

FACT Membership Dues $ _____

Base Premium Amount *(includes taxes and fees)* + _____

OPTIONAL BENEFITS — See current brochure and inserts for availability

☐ Supplemental Accident
☐ $1,000 ☐ $1,250 ☐ $1,500 ☐ $2,000 ☐ $2,500
☐ $3,000 ☐ $3,500 ☐ $3,650 ☐ $4,000* ☐ $5,000*
☐ $5,500* ☐ $6,000* ☐ $6,350*
*(*Not available with Silver HSA 100®)* + _____ 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 Telephone Number

_____

Street City State ZIP

☐ 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

SECTION 4

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:

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

9. In the last 5 years, was any applicant convicted of a felony, DUI, or had his/her driver's license suspended or revoked? ☐ YES ☐ NO

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 _____

SECTION 5

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. **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.

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

(8) The policy/certificate requires some medical services to be authorized by UnitedHealthcare Life or its representative before the services are provided, and benefits for these services may be reduced if the prior authorization is not obtained.

I have received a Notice of Information Practices and a Conditions Prior to Coverage.

X _____ / / _____
Primary Applicant (You) Date

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

X _____
Spouse (if to be covered)

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 William C. Stapleton
Print Full Name

8577379
Broker Number

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.

ADNI-UL-1013

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

X _____ / / _____
Primary Applicant (You) Date

X _____
Spouse (if to be covered)

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

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 under 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.

X _____

Signature of Primary Applicant

Primary Applicant's Social Security No. _____

Applicant's Spouse Social Security No. _____

Per the USA Patriot Act: 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

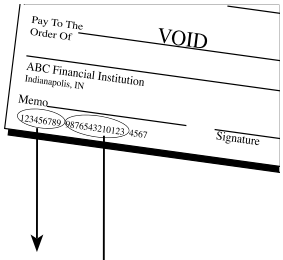
Authorized User's _____
Social Security No.

HSA-UL-1013

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. _____

EFT-UL-1013

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 _____

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

Billing ZIP Code: _____

CC-UL-1013

Card Number: _____

X _____
Signature of Authorized User

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