



**UnitedHealthCare\***  
INSTRUCTIONS FOR CHANGE FORM

**PREMIUM  
PAYMENTS:**

UnitedHealthCare applicants **must send in the 1st initial premium payment with the enrollment form.** Applications **WILL NOT** be processed without the correct premium or attached check payments. **Checks must be payable to UnitedHealthCare.**

**Upon coverage issue,** UnitedHealthCare will provide a monthly billing sent directly to you.

**Please note:**

- Coverage issued by UnitedHealthCare cannot be retroactively cancelled.
- Coverage can be cancelled in advance of coverage effective date.
- Premiums earned for coverage provided during the month will not be refunded to the subscriber.
- Unearned premiums (premiums paid for coverage not provided) will be refunded.
- Billing questions need to be directed to UnitedHealthCare at the phone number shown on your billing.

\*This program is a special benefit for members of local Realtor® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your local Association, The Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.



**F. Signature (continued)**

understand the purpose of the disclosure and use of my information is to allow The Company and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying The Company in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents, I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. 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 application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

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| Date | Employee Signature for all applying and waiving | Spouse/Dorn. Partner Signature (if applicable) |
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