

UnitedHealthCare*
ENROLLMENT INSTRUCTIONS

Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.

**MEMBER /
APPLICANT
INFORMATION:**

Member/Applicant: _____
Local REALTOR® Assoc. Name: _____
E-Mail Address: _____
Requested effective date of coverage: 1st of _____, 20

New Enrollee [] Current Benefits Store Member Changing Plans []

Remember to attach your business card and this form to your application
The applicant must be a member of a Local REALTOR® Association.
W-2 Employees – Please call our office at 800-446-2663

IMPORTANT!

Can you show proof of current medical coverage? [] Yes [] No

If “Yes”, you must attach a copy of your current Membership Card to your application.
If “No”, you must call our office at 1-800-446-2663 prior to completing your application.

**SELECTING
YOUR PLAN:**

[] \$3500 Deductible HSA Compatible PPO Plan (Definity HSA 6C-J)

**COMPLETING THE
APPLICATION:**

USE BLACK INK AND COMPLETE SECTIONS A, B, D, E, F, and G ONLY.
(DO NOT COMPLETE THE EMPLOYER SECTION or SECTION C.)

**PROCESSING
REQUIREMENT:**

NOTE: Incomplete Applications or applications without the 1st Month’s premium included cannot be processed.

If you are unsure of your premium payment amount, please be sure to request a Free Quote on our website at www.BenefitsStore.com before submitting your enrollment form and check payment.

**EFFECTIVE
DATE OF
COVERAGE:**

Applications are accepted (must be received in our office) through the end of the current month for coverage to be effective the 1st of the following month. **To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.**

TO ENROLL:

Review the application for accuracy, sign, date, and return to us with your premium. **Make Checks Payable to: UnitedHealthCare.**

U.S. MAIL (1st Class or Priority)
ATTN: ENROLLMENT –UHC
Benefits Store, Inc.
PO Box 68, Orinda, CA 94563-0068

OVERNIGHT/EXPRESS DELIVERY ONLY
ATTN: ENROLLMENT - UHC
Benefits Store, Inc.
85 High Eagle Road, Alamo, CA 94507-2009

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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.

APPLICATION PROCESSING:

Allow 12 business days for the processing of your application and for you to appear in UnitedHealthCare's database. **DON'T DELAY – ENROLL TODAY!** ID Card(s) (from United HealthCare) are normally generated within 15 working days from the time we receive your application. If we do not receive your application until the 20th of the month you may not receive your ID card(s) until the 15th of the following month. To avoid this delay we urge you to submit your application to us as soon as possible.

THOSE APPLYING WITH CURRENT COVERAGE:

Remember, everyone applying during the Open Enrollment will be accepted! Coverage is guaranteed. Those of you that have paid your current coverage premiums in advance need to request an effective date for your new coverage that will match the date when your current coverage ends. Those of you that are within the "grace period" for premium payment of your current coverage need to verify with your current insurer the length of time allowed for your coverage before cancellation.

IMPORTANT!!!

You should not cancel your current coverage until you are notified of your new coverage.

For verification of your new coverage, E-mail: Enrollment@BenefitsStore.com

ADDITIONAL INFORMATION – PLEASE READ

To cancel your coverage or to revoke your application, we require a written notice of your intent including your signature and your requested date of cancellation. We ask this statement be written on a copy of your billing statement and faxed to 925-855-2051 or mailed to our Membership Accounting department. Please visit our website for additional contact information. This notice must be received no later than 12 noon 1 business day (M-F) BEFORE the last business day of the month in which you wish to cancel. For example, April 29, 2008 for an effective cancellation date of April 1, 2008.

By signing your enrollment application you represent that all of the information you have included is complete and accurate, and that you accept all terms of this application and supporting documentation.

*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 Association, 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)

I 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.

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