□ Optimum Choice, Inc. ("The Company")

[800 King Farm Boulevard, Rockville, MD 20850]

☐ MD-Individual Practice Association, Inc. ("The Company")

Employee Enrollment Form

☐ UnitedHealthcare of the Mid-Atlantic, Inc. ("The Company")

☐ UnitedHealthcare Plan of the River Valley, Inc. ("The Company")

[800 King Farm Boulevard, Rockville, MD 20850]



[1300 River Drive, Suite 200, M	oline, IL 612	65]		[800 K	ing Farm Bo	ouleva	rd, Rock	/ille, MD 20850]		
□ UnitedHealthcare Insurance Com [185 Asylum Street, Hartford, C		Compan	у")							
To speed the enrollment process	, please be t	thorough	n and fill out all	sections t	that apply.					
To Be Completed by Employe	Requ	uested E	ffective Date of	Coverage	/Date of Ch	ange	/	/		
Group Name							Policy No	umber		
Date of Hire /	/		Reason for Application □ New Group Plan □ Life Event/Date		□ New Hire		Employee Type (Check all that apply)			
Position/Title		□ Life Event/Da □ Status Chang	Open Enrollment □ Late		□ Active □ COBRA □ State Continuation Start dt// End dt// □ Hourly □ Salary □ Union □ Non-Union □ Retired					
Hours Worked per week		 □ Dependent Ac □ Change Name □ Part time to F 								
Salary \$ Required or LTD PI	only if Life, S an based on	STD.	□ Waiving Cove □ Other	rage	□ Termina	_ 01110		·		
A. Employee Information	If yo	u are w	aiving all cove	age, pleas	se complete	e sect	ions A ar	nd F.		
Last Name First I			Name		MI	Soci	cial Security Number			
								- -		
Address		Apt #	City		State	Zip	Code	Home/Cell Phone		
Date of Birth / /	Gender □ M □ F	Emai	ail Address					Work Phone		
Marital Status □ Single □ Married □ Divorced □ Widowed				Do you use tobacco?¹ □ Yes □ No						
Language Preference, if not English				If yes, are you currently participating in a tobacco cessation program or do you intend to join one? $\ \square$ Yes $\ \square$ No						
Primary Care Physician ² Existing Patient? ☐ Yes ☐ No					Primary Care Dentist ³					
Physician First & Last Name					Dentist First & Last Name					
Address					_ ID#					
ID#IIIIIIIII					Existing Patient? □ Yes □ No					

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of the Mid-Atlantic, Inc. or UnitedHealthcare Plan of the River Valley, Inc. or Optimum Choice, Inc. or MD-Individual Practice Association, Inc.

Dental coverage provided by UnitedHealthcare Insurance Company

Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company Vision coverage provided by UnitedHealthcare Insurance Company

B. Family/D	ependent Inform	ation	Lis	t All Enrol	ling (Attach sheet if nece	essary)					
Relationship ⁴	Last Name	st Name			First Name			Sex □ M □ F	Date	of Birth /	/	
Spouse /Domestic Partner Social Security Number Do you in a t						ou use tobacco?¹ □ Yes □ No If yes, are you currently participating obacco cessation program or do you intend to join one? □ Yes □ No						
Primary Care Physician ² Existing Patient? □ Yes □ No						Primary Care Dentist ³						
Physician First & Last Name						Dentist First & Last Name						
			ID#									
ID#I_I			- II	lI	Exis	ting Patient? □ Yes	s □ No)				
Relationship⁴ Last Name Firs					ame MI Sex Date of Birth							
Dependent	Social Security N			Do you in a tob	use t	obacco?¹ □ Yes □ cessation program or	No If y do you	es, are you of intend to jo	current in one?	ly participa ? □ Yes	ating □ No	
Primary Care	Physician ²	Existing Patient?	⊐ Yes	□No	Prin	nary Care Dentist ³		Existing F	Patient'	? □ Yes	□ No	
Physician Firs	t & Last Name											
Address					ID#							
ID#I_			- II	I	Pern	nanently disabled ar	nd age	26 or older	.5 □ Ye	es 🗆 No		
Relationship ⁴ Last Name				First Name			MI	Sex □ M □ F		of Birth /		
Dependent Social Security Number Do you use tobacco?¹ □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No												
Primary Care	Primary Care Physician ² Existing Patient? Yes No Primary Care Dentist ³ Existing Patient? Yes No											
Physician First & Last Name Dentist First & Last Name												
Address ID#												
ID#I_I			-	lI		nanently disabled ar						
Relationship ⁴	Last Name			First Nam	<u> </u>	-	MI	Sex	Date	of Birth		
——————										/	/	
Dependent Social Security Number Do you use tobacco?¹ □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No									ating □ No			
Primary Care Physician² Existing Patient? □ Yes □ No Primary Care Dentist³ Existing Patient? □ Yes □ No								□ No				
Physician First & Last Name					Dentist First & Last Name							
Address ID#												
ID#IIIIIIIIII Permanently disabled and age 26 or older ⁵ \(\text{Yes} \) No												
(1) Tobacco means on average (excludin Select Plus, and oth dependents. (3) Plea dependent does not dependent upon sub	all tobacco products, inclu ng religious or ceremonial er products requiring you ase see employer represen reside with eligible emplo sscriber for support and is	ding, but not limited to, cigarette use) within the past 6 months b to choose a Primary Care Physic tative as some dental plans requ yee, please provide address on a not able to be self-supporting b	es, cigars, y someon ian (PCP) ire a Prim separate ecause of	and chewing to e of legal age to , you must use ary Care Dentis sheet. (5) If yo a physically or	obacco. o purcha the Uni st (PCD) u answe mentally	You should only check the "ase tobacco in the state of re tedHealthcare directory of pi selection. (4) For court ordered "Yes" for Disabled and t y disabling injury, illness or o	yes" box sidence. roviders to lered dependenced depend	above if tobacco (2) For UnitedH o choose a PCP endent, legal doo dent child is 26 please attach a	o was use lealthcare for yours cumentat years of a medical	ed four or mon Compass, Na self and each ion must be a age or older, u certification o	re times per weel avigate, Select, of your covered attached. If a unmarried, chiefly of disability.	
C. Product	Selection	If your employer off selected for the Life	ers a cl and Ac	noice of pla cidental De	ns, in ath &	which you or your do dicate which plan you Dismemberment (AD s. Benefit offerings an	are se &D), S	lecting. Indi upplementa	cate th I Life, S	Short-Tern	n Disability	
Person		Medical		Dental		Vision	Ва	asic Life/AD)&D	Supp I	Life/AD&D	
Employee										□\$		
Spouse/Dome	stic Partner						□ \$			□ \$		
Dependent							□ \$			□ \$		
Person		STD		LTD								
Employee												

Employee Name									
C. Product Sele	ection (cont	inued)							
Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare) Relationship									
Primary									
Secondary									
D. Prior Medical Insurance Information									
Within the last 12	months, have	e you, your spous	e, or your de	ependents had a	ny other me	dical coverage?			
□ NO □ YES (if yes, please complete this section.) Prior medical carrier name Effective date//_ End date//_									
	Prior medical carrier name Effective date// End date// Prior coverage type: □ Employee □ Spouse □ Child(ren) □ Family								
E. Other Medic				• • •		ch sheet if necessar	y.)		
			pouse or an	y of your depend	dents be cov	ered under any othe	r medical health plan or policy,		
including another	UnitedHealtho	care plan or Medi	care? 🗆 YE	S (continue com	pleting this	section) 🗆 NO (skip	the rest of this section)		
Name of other car	rier					-			
Other Group Medical Coverage Information (only list those covered by other plan)			Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage			
Employee:									
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 – Employ	yee Informati	on: If enro	lled in Medic	are, please attac	ch a copy of	your Medicare ID ca	rd.		
☐ Enrolled in Part				ible for Part A*		,	chose not to enroll)**		
□ Enrolled in Part						,	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 Are you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date///									
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. ** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain									
coverage under Medicare Part A, Part B, and/or Part D as applicable.									
F. Waiver of Coverage Declining coverage due to existence of other coverage: I understand that by waiving coverage at this time, I									
I decline all coverage for: Myself Dependent Children Myself and all dependents Detailing coverage due to existence of other coverage. Tuitderstand that by waiving coverage at this time, will not be allowed to participate unless I qualify at special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. Tri-Care I (we) have no other coverage at this time Other Other						participate unless I qualify at a iod or as a late enrollee, if			
Date Employee Signature if waiving coverage									

G. Signature

I authorize "The Company(ies)" checked on page one to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to "The Company(ies)". I understand that the purpose of the disclosure and use of my information is to allow "The Company(ies)" to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my "Company(ies)" representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, "The Company(ies)" also requires that I acknowledge the following, which I do: I understand that 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, is valid for 30 months from the date it is signed (and for the term of coverage of the policy for the purpose of collecting information in connection with reviewing and/or processing a claim for benefits). I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that I am completing a joint life and health application and that each response must be complete and accurate to the best of my knowledge and belief. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that "The 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.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective. In accordance with Virginia law, the validity of a policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. In addition, and in accordance with Virginia law, no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1.) After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2.) Unless the statement is contained in a written instrument signed by him. This shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

Please maintain a copy of this authorization for your records.

You or your authorized representative are entitled to receive a copy of this authorization.

I certify that I have read, or have had read to me, this completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Date	Employee Sigr	nature for all applying	Spouse Signature (if applying for coverage)								
H. Census Info	H. Census Information (optional)										
, ,	•	on is optional and is not required. Data collecte cific programs to enhance their well-being. This	,								
1. Race, check all	that apply:	□ White □ Black, African-American □ Native Hawaiian/Pacific Islander	□ American Indian/Alaska Native□ Other Race, please specify	□ Asian							
2. Are you of Hisp	oanic or Latino	origin? □ Yes □ No									