Request for Portability of 2018 Accident Insurance

Forms UHI-ACC-POL et al

UnitedHealthcare®

PLEASE NOTE: This form must be received by UnitedHealthcare within 31 days of Date of Termination.

All sections of this form must be complete for us to process your request.

The Employee or applicable Dependent will not be eligible to port the Accident coverage if the Employee has not been insured under the policy for at least 6 months (time limit may vary by state). Refer to your COC for other eligibility requirements.

Sections A, B and C to be completed by *Employer*

A. Information about EMPLOYEE

Employee Last Name	First Name	M.I.	Date of Birth	Date of Hire

Monthly Premium	Initial Effective Date	Date premium paid to

Date of Termination	Reason for Termination

Employee's Benefit Plan (Plan A, B or C, if specified)	Social Security Number

B. Information about Spouse and Dependent(s) (Complete only when the Dependent Portability option is available.)

Dependent Name and Relationship	SS#	Date of Birth	Benefit Plan (Plan A, B or C, if specified)	Monthly Premium

C. Employer Information

Employer's Signature	Printed Name

Company Phone Number	Date

Group Name	Group Policy Number	Date this form given to Employee

Sections D, E, F and G to be completed by *Employee*

D. Employee Information

Address (Street, City, State and ZIP code)	Phone Number:

E. Insurance Coverage You Are Requesting To Port

Check appropriate election (you may only port coverage that is shown above by your employer as being in force and portable per the Group policy):

☐ Employee
☐ Employee and Dependent Spouse
☐ Employee and All Dependents
☐ Employee and Dependent Children

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F. Quarterly or Annual Premium Calculation

Please choose either Quarterly or Annual billing: ☐ Quarterly or ☐ Annual

Quarterly Premium Calculations	Annual Premium Calculations
Employee's quarterly premium is calculated: Monthly premium x $_____	Employee's annual premium is calculated: Monthly premium x 12 $ _____ This is your new Annual Premium

If you are requesting portability coverage for your spouse and/or dependents, a similar calculation should be done for your Spouse and Dependent Child(ren) and listed below.

Employee's premium amount: $_____

Spouse's premium amount: $_____

Dependent's premium amount: $_____

Total payment required with this form (Employee + Spouse+ Dependents): $_____

G. Employee Signature

Enclosed with this form is my first quarter or annual premium. I hereby authorize UnitedHealthcare Insurance Company to begin billing me directly for my Accident Insurance coverage.

Insured Employee _____ Date _____

Make your check payable to UnitedHealthcare. Mail this completed form with your premium to:

UnitedHealthcare
12700 Whitewater Drive
MN022-0310
Minnetonka, MN 55343
1-877-683-8601

UnitedHealthcare Use Only		
Date Received	Date Acknowledgement Mailed	Group Number