Virginia Medical Plans

Application Instructions for UnitedHealthcare

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans for signature. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.
Don't forget to **enclose a check for the required payment made payable to UnitedHealthcare Life Insurance Company** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submiting it to UnitedHealth for processing. This may reduce the underwritting time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800-867-0800 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

Virginia Medical Plans

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Virginia Medical Plans
FAX# 888-514-4258

Dear Virginia Medical Plans,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name ____

E-mail ____

Date ____

Time ____

☐ Please contact me at this phone number ____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Virginia Medical Plans at 800-867-0800 to verify receipt of my application.

I will send the original application as soon as I have been contacted by Virginia Medical Plans with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

FACT Membership Enrollment Form — Virginia

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 — GREEN BAY, WISCONSIN
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

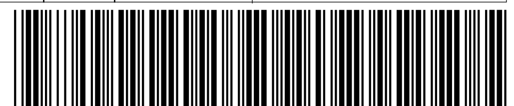
g. Marital Status: ☐ Married ☐ Single

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
☐ Platinum Copay Select℠

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)* + ______________

☐ 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 ________

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

SECTION 4

Statement of Understanding —
Review the completed application and read the section below carefully before signing.

I certify that I have read this application or had it read to me. I represent that the answers and statements on it are true, complete, and correctly recorded. I realize that any false statement or misrepresentation in the application may result in voidance of coverage under the policy. **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.

(9) **The UnitedHealthcare Life coverage may pay reduced benefits if you obtain other similar insurance covering the same loss.**

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

X ______________________________ / /
Primary Applicant (You) Date

X ______________________________
Spouse (if to be covered)

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

SECTION 5

Broker Statement: Review the completed application before signing below.

I verify that each question on the application was completed by the applicant(s). I certify that the applicant has read or had read to him the completed application. The applicant is fully aware that any false statement or misrepresentation may result in voidance of coverage under the policy. The applicant has received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X ______________________________
Signature of Licensed Broker

X Jonathan Katz
Print Full Name

1 5 8 5 6 1 6
Broker Number

jkatz@vamedicalplans.com
Broker Email Address

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

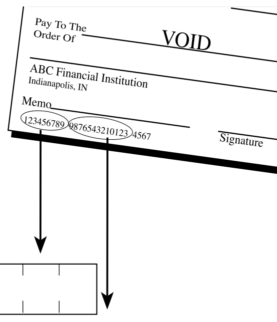
Authorized User's [ ]
Social Security No.

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.