APPLICATION FOR DENTAL INSURANCE
UNITEDHEALTHCARE INSURANCE COMPANY
185 ASYLUM STREET, HARTFORD, CONNECTICUT 06103-0450

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Birth Date
☐ Male ☐ Female	Primary (You)	____/____/_____
☐ Male ☐ Female	Spouse	____/____/_____

Permanent Home Address (PO Box/PMB is not allowed)

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different from permanent home address)

Street (Include Apt.)	City	State	ZIP Code

Contact Information

Phone Number	Optional Email
( )	

Plan Selection

Plan Start Date
Your Plan will start on the first day of the month following receipt and approval of this Application Form and receipt of your first month's payment. If you would like your Plan to start on a later date (the first day of a future month), please indicate the date: ____/_01_/_____

Plans *(Choose One)*	☐ DVH 500	☐ DVH 1000	☐ DVH 2000	☐ DVH 3000
	☐ DVH 500 PLUS	☐ DVH 1000 PLUS	☐ DVH 2000 PLUS	☐ DVH 3000 PLUS

Initial Payment

Estimated Monthly Premium **$** _____

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete. I understand and agree that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by UnitedHealthcare Insurance Company (UHIC) with this application.

(2) The primary applicant must be age 64 and 11 months or older on the plan effective date to be eligible for coverage.

(3) An intentional misrepresentation of fact or fraudulent information on this application may result in voidance of coverage and claim denial subject to the Time Limit on Certain Defenses and Repayment for Fraud, Misrepresentation or False Information provisions.

(4) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy or policies that may be issued.

(5) If an application is approved, insurance will be effective:
   (a) The first day of the month following receipt and approval of this application and receipt of your first month's payment; or
   (b) The first day of a future month requested by you.

(6) The agent is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

(7) If UHIC rejects this application, under no circumstances will any benefits be payable. Receipt of payment by UHIC does not constitute approval of my application or create UHIC coverage.

(8) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(9) I acknowledge that applicant has access to/has received a Guide to Health Insurance for People with Medicare. The Guide to Health Insurance for People with Medicare is available at: https://stage.uhone.com/api/supplysystem/?Filename=Medicare-Medigap-guide.pdf

(10) THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature Information

	Signature	Date Signed
Primary Applicant		

Agent Information – Review the completed application before signing below.

Agent certifies that he/she has truly and accurately recorded on the application the information supplied by the applicant.

Agent Name (Please Print) (First Name, MI, Last Name)	Signature of Licensed Agent (required)
Agent ID (required)	Date Signed (required) (Month, Day, Year)
Agent Email Address	Agent Phone Number

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department (1-800-595-6053) or state health insurance assistance program (SHIP) (1-877-293-7447).

45574-X-16-0918

Payment Method - Select one below.

☐ EFT – Complete EFT Authorization below

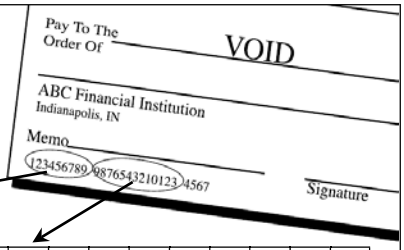
☐ Credit Card – Complete Credit Card Authorization below

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:

I (we) hereby authorize UnitedHealthcare 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. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____
Day Date Signed

Only select a draft date between the 1st and 28th of the month.

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

☐ CREDIT CARD AUTHORIZATION – ONLY IF PAYING BY CREDIT CARD:

I authorize UnitedHealthcare Insurance Company to bill my MasterCard/Visa/American Express/Discover account.

Type of Card: ☐MasterCard ☐Visa ☐American Express ☐Discover Exp Date _____ _____
Month Year

Billing ZIP Code: _____ Card Number: _____

X _____ Charge On _____
Signature of Authorized User Day

Only select a charge date between the 1st and 28th of the month.

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

ELECTRONIC DELIVERY TERMS AND CONDITIONS

You will receive your Required Plan Communications electronically instead of receiving paper copies through the U.S. Mail. We will send you an email when a document is ready to view online.

Not all communications require permission before sending electronically. This Notice only applies when permission is required. Communications are based on the Plan(s) you have. You will get new types of communications as they become electronic. If there is not an electronic version, we will send by mail. Occasionally, in addition to electronic delivery, you may also receive a hard copy document.

You can request a free paper copy of documents that we are required to provide you by calling the phone number on your insurance ID card.

Your consent remains in effect until you withdraw it. You may withdraw your consent at any time and choose to begin receiving paper mailings by changing your delivery preferences on the member website or by calling the phone number on your insurance ID card. Changes may take up to seven business days to process.

It is your responsibility to notify us of any changes to your email address and your failure to do so may cause delayed communications. If attempts are made to deliver information to any email address you provide and the message is returned as undeliverable after several attempts and that email address is not updated by you, we will assume that you have withdrawn consent for electronic delivery and will begin sending the information to you in paper format. To ensure that you continue to receive emails from us, add the email "from" address to your email address book or safe list. To update your email address, go to your member website or you can call the phone number on your insurance ID card.

If you change plans or add a benefit, program, product or service, we will use the same contact information, when possible, to electronically deliver Required Plan Communications related to those services.

Requirements to access and retain information – in order to receive and retain electronic communications, you must have access to a computer or other device that is capable of mobile or internet access and complete your registration for the member website. This page contains documents in PDF format. PDF (Portable Document Format) files can be viewed with Adobe® Reader®. If you don't already have this viewer on your computer, download it free from the Adobe website (http://get.adobe.com/reader/).

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

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

_____
Primary Applicant's *(Your)* Email Address

_____
Parent/Guardian's *(if you are a minor)* Email Address

_____
Date

_____
Policy Number

ATTENTION: Free language assistance services and free communications in otherformats, such as large print, are available to you. Call 1-800-657-8205. (TTY 711).

ማሳሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ ሕትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በ 1-800-657-8205 ይደውሉ።

لاحظة: إذا كنت تتحدث اللغة العربية (Arabic)، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم 1-800-657-8205.

দেখুন: আপনি যদি বাংলায় (Bengali-Bangala) কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো, অন্যান্য ফরম্যাটে বিনামূল্যে যোগাযোগগুলি, আপনার জন্য উপলব্ধ। 1-800-657-8205-এ কল করুন।

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Cambodian-Mon-Khmer) សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ 1-800-657-8205។

ATENSHUN: Gare kapetal Faluwasch (Carolinian), ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale toor kapetal. Ko yegili 1-800-657-8205.

ATENSYON: Yanggen fifino' hao CHamoru (Chamorro), guaha setbisio siha para hågu ni' fåtto, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dângkolo i inemprenta. Ågang 1-800-657-8205.

請注意：如果您說中文 (Chinese - Traditional)，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電 1-800-657-8205。

ATTENTION: Si vous parlez français (French), des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le 1-800-657-8205.

ATANSYON: Si w pale Kreyòl Ayisyen (French Creole-Haitian Creole), gen sèvis lang gratis ak kominikasyon nan lòt fòma ki disponib, tankou sa ki enprime akgwo lèt yo. Rele 1-800-657-8205.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie 1-800-657-8205 an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά (Greek), υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε 1-800-657-8205.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. 1-800-657-8205 પર કૉલ કરો.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। कॉल करें 1-800-657-8205।

LUS TSEEM CEEB: Yog tias koj hais Lus Hmoob (Hmong), muaj cov kev pab cuam txhais lus pub dawb thiab muaj kev sib txuas lus dawb ua lwm hom ntawv, xws li luam ntawv loj rau koj. Hu rau: 1-800-657-8205.

ATENSION: No agsasaoka iti Ilocano (Ilocano), magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti 1-800-657-8205.

ATTENZIONE: se parla italiano (Italian), può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero 1-800-657-8205.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。1-800-657-8205 にお電話ください。

알림 사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사소통 매체를 이용하실 수 있습니다. 1-800-657-8205 번으로 전화해 주십시오.

ໝາຍເຫດ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ (Lao), ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ, ເຊັ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ກະລຸນາໂທຫາ 1-800-657-8205.

BAA'ÁKONÍNÍZIN: Diné (Navajo) saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáł łahgo át'éego bee hadadilyaa bee ahxił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Kohjį' 1-800-657-8205 hodíilnih.

ध्यान दिनुहोस्: तपाईंले नेपाली (Nepali) बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। 1-800-657-8205 मा कल गर्नुहोस्।

WICHDICH: Wann du Deitsch (Pennsylvania Dutch) schwetzscht, kenne mer dich Schprooch-Hilf un annri Sadde Schreiwes griege, so wie Grooss-Druck (large print), unni as es dich ennich eppes koschde zellt. Call 1-800-657-8205 uff.

توجه: اگر به زبان فارسی (Persian-Farsi) صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با 1-800-657-8205 تماس بگیرید.

UWAGA: Dla osób mówiących po polsku (Polish) dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod numer 1-800-657-8205.

ATENÇÃO: se você fala português (Portuguese), tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para 1-800-657-8205.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। 1-800-657-8205 ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ! Если вы говорите на русском языке (Russian), вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по номеру 1-800-657-8205.

FA'AALIGA: Afai e te tautala i le Faa-Samoa (Samoan-Fa'asamoa), o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au i le 1-800-657-8205.

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Wac 1-800-657-8205.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al 1-800-657-8205. (TTY 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa 1-800-657-8205.

โปรดทราบ หากคุณ**พูดภาษาไทย** (Thai) ได้
คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น
การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทร 1-800-657-8205

ЗВЕРНІТЬ УВАГУ! Якщо ви розмовляєте українською (Ukrainian), ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на номер 1-800-657-8205.

توجہ دیں: اگر آپ اردو (Urdu) زبان بولتے ہیں تو زبان کی معاون خدمات اور دیگر فارمیٹس میں مواصلات،
جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ کال کریں 1-800-657-8205۔

LƯU Ý: Nếu quý vị nói Tiếng Việt (Vietnamese), quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi 1-800-657-8205.