

Request for Portability of Hospital Indemnity Insurance*

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
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
Employee's coverage amount	Monthly premium	Initial Effective Date		Date premium paid to
Reason for Termination			Date of Termination	
Annual salary at Termination			Social Security Number	

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

Dependent Name and Relationship	Social Security Number	Date of Birth	Coverage Amount	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:
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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):

- | | |
|------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Employee | <input type="checkbox"/> Employee and Dependent Spouse |
| <input type="checkbox"/> Employee and All Dependents | <input type="checkbox"/> Employee and Dependent Children |

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F. Quarterly or Annual Premium Calculation	
Please choose either Quarterly or Annual billing: Quarterly or Annual	
Have you used tobacco of any kind during the last 12 months? Yes No	
Quarterly Premium Calculations for the first 12 Months of Portability	Annual Premium Calculations first 12 Months of Portability
Employee's quarterly premium is calculated:	Employee's quarterly premium is calculated:
Monthly premium x 3 = \$ **	Monthly premium x 12 = \$ **
**This is your new Quarterly Premium for the first 12 Months of Portability. See NOTE below.	**This is your new Annual Premium for the first 12 Months of Portability. See NOTE below.
NOTE: After the first 12 months your premium rates may increase. You will receive an invoice noting any change.	
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 ported Hospital Indemnity Insurance coverage.	
Insured Employee	Date

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

UnitedHealthcare
 Attn. Portability Billing
 9700 Health Care Lane
 MN017-W400
 Minnetonka, MN 55343

1-877-683-8601

UnitedHealthcare Use Only		
Date Received	Date Acknowledgement Mailed	Group Number