UnitedHealthcare®

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

Date of Termination	Reason for 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: (____) _____-_____

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

*In some states, Portability may be referred to as Continuation

UnitedHealthcare

Request for Portability of Hospital Indemnity Insurance*

F. Quarterly or Annual Premium Calculation

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

Quarterly Premium Calculations for the first 12 Months of Portability	**Annual Premium Calculations first 12 Months of Portability**
Employee's quarterly premium is calculated: Monthly premium x 3 = $_____** **This is your new Quarterly Premium for the first 12 Months of Portability. See NOTE below.	Employee's quarterly premium is calculated: Monthly premium x 12 = $_____** **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
9700 Health Care Lane – 7th Floor
MN017-W700
Minnetonka, MN 55343

1-877-683-8601

UnitedHealthcare Use Only		
Date Received	Date Acknowledgement Mailed	Group Number

*In some states, Portability may be referred to as Continuation

Rev. 06/18)