

IMPORTANT:

UHC Enrollment Update

\$today_long



Dear Agents,

Effective October 8th, 2018, you will see an update to your United HealthCare member enrollments. If paying by Credit Card, the member will be required to enter their payment information during the E-signature process.

When you get to the Payment method section of the enrollment:

- Select the form of payment method they wish to use
- If paying by credit card, the message will display indicating the member will enter payment information. (EFT payment entry will be available to you, the agent, to enter as usual)
- Check the authorization acknowledgment box
- Submit the E-signature for the member to complete the remainder of the information

Payment Method

☒ Credit Card
 
☐ ACH Bank Draft
 

Member will enter payment information.

Authorization

Producer/Agent Information - Review the completed application information before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

For North Carolina Applications:
Each question on the application was completed by the applicant(s). If not completed by the applicant, I verify that I have truly and accurately recorded the information supplied by the applicant. The applicant has received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage. I agree with the answer given for Question O2, "Does any applicant intend to replace any existing coverage in force?" (If the response shown for Question O2 does not reflect your understanding, please provide an explanation in the notes box located in the application form. Notes are not visible to your prospect, they are available for broker use only.)

☒ By checking the box, I acknowledge that I have verified the enrollment information.

Signature

Cell Phone

Email Address

The esignature document will have two steps if paying by credit card. On the first page, the member will see an overview of the plans they are applying for with the payment fields listed at the bottom of the page. Please have your member complete their payment information and move on to sign the document. The next page will display the actual esignature document.

A payment will not process at this time. You will receive a message when the document has been signed and then submit the enrollment as usual. The payment will process according to the normal application process currently in place.


Payment Summary Information

Applicant Information

Name	Gender	Date of Birth
Testing Testforsign	F	06-29-1979
Address	Phone	
123 Main St, Leonard, TX 75452	(503) 419-8115	
Email		
lauren.reese@adroithealthgroup.com		

Product Information

Health ProtectorGuard



PLEASE NOTE: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Notice: The answers to these questions will be transferred to the application for insurance. After the questions are answered, please review the application information; sign it, and the related forms, electronically.
Review and verify the following information for accuracy. If any of the information listed herein is inaccurate, advise your agent to correct the information and resubmit the corrected signature prior to you signing below.

APPLICATION FOR FIXED INDEMNITY INSURANCE
GOLDEN RULE INSURANCE COMPANY
INDIANAPOLIS, IN 46278-1719

This product provides benefits in a stated amount regardless of the actual expenses incurred.
Golden Rule Insurance Company is the underwriter of these insurance plans.

Plan Selection

Health ProtectorGuard Choice Value

Click HERE to access the Health ProtectorGuard Brochure
(<https://www.1administration.com/media/1274/DOCUMENTS/UHC/HPG%20Brochure.pdf>)

Application Questions:


NOTE: regarding the Requested Effective Date listed below, see Statement of Understanding section

Estimated Monthly Premium: \$122.12 per Month for Choice Value

Monthly Network Fee \$3.25 per Month

Requested Effective Date: 10/04/2018

Payment Information

☒ Credit Card
 

Credit Card Number

Card Expiration Date

Month

Year

Security Code/CV2

First Name

Last Name

Address

City

State

Zip Code

If you have any questions, please contact agentservices@adroithealthgroup.com or call 800-319-7061.

Thanks,
Adroit Health Group