# UnitedHealthcare of Georgia
## Benefit Options Checklist

**Group Name:** __________________________________________________________  **Eff. Date:** _______________________________

**Account Executive:** ______________________________________________________________________________________________

**Medical Product:** ☐ UnitedHealthcare OR ☐ UHC River Valley

### 1. If purchasing an HSA product, will you be using Optum Health Bank for the Administration?
   - If yes, please include the completed Optum Health Bank Notification Form with your submission.
   - River Valley: At this time, HSA is not available on the Heritage product.

### 2. If HRA administration has been selected, is the HRA Benefit Form attached/completed?
   - River Valley: At this time, HRA is not available on the Heritage product.

### 3. Does this group have out-of-state employees not applying?
   - If yes, please explain why?

### 4. Are you offering coverage to Domestic Partners? If yes, additional paperwork will be needed for those individuals requesting coverage. NOTE: This coverage is not offered in all States.

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**INDICATE APPROPRIATE PLAN CODE SELECTIONS BELOW**

### Medical Plan Code(s) and Pharmacy Plan Code(s)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Base Location*: __________________________</td>
</tr>
<tr>
<td></td>
<td>Medical Plan: ___________ RX Plan Code: ___________</td>
</tr>
<tr>
<td></td>
<td><strong>Option 2</strong> – Additional Employee Locations- Multi-Site  <strong>Total # of Locations:</strong> __________________________</td>
</tr>
<tr>
<td></td>
<td>Location 1: __________________________</td>
</tr>
<tr>
<td></td>
<td>Medical Plan: ___________ RX Plan Code: ___________</td>
</tr>
<tr>
<td></td>
<td>Location 2: __________________________</td>
</tr>
<tr>
<td></td>
<td>Medical Plan: ___________ RX Plan Code: ___________</td>
</tr>
<tr>
<td></td>
<td>Location 3: __________________________</td>
</tr>
<tr>
<td></td>
<td>Medical Plan: ___________ RX Plan Code: ___________</td>
</tr>
</tbody>
</table>
|        | **Option 3** – Dual Option Plans -
|        | * Please indicate on employee enrollment form which plan each employee is enrolling in OR include a census with this information. |
|        | Medical Plan: ___________ RX Plan Code: ___________ |
|        | and |
|        | Medical Plan: ___________ RX Plan Code: ___________ |

*The base location is where the plurality of employees resides. (If only one location, skip Option 2)*

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**Optional 24 hour coverage**

<table>
<thead>
<tr>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>For owners and partners only</td>
<td></td>
</tr>
</tbody>
</table>

**Chiro Rider ______________________**

**Note:** Additional premium required for this rider on the Heritage Product only

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**Automatic Bank Draft**

<table>
<thead>
<tr>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pls. complete ACH form and attach voided check</td>
<td></td>
</tr>
</tbody>
</table>

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**Consumer Choice Option (CCO)**

<table>
<thead>
<tr>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>
| Enrolling employees.  
**NOTE:** 17.5% additional premium |
ANCILLARY PLAN SELECTIONS
Please indicate appropriate plan code(s) below

Dental Plan Code(s)

Option 1 – Base Location*:

☐ PPO _____________  ☐ Indemnity ______________

**Proof of Prior Dental documents attached (see below)?
☐ Yes  ☐ No
If no, the group will be subject to the waiting period if such a plan was chosen.
* The base location is where the plurality of employees reside.

Option 2 – Additional Employee locations
Total # Locations: ____

Location 1: __________________________

☐ PPO _____________  ☐ Indemnity ______________

Location 2: __________________________

☐ PPO _____________  ☐ Indemnity ______________

Vision Plan:
Plan - __________________________

Disability or Supplemental Life:
STD Plan - __________________________
LTD Plan - __________________________

Supplemental Employee Life/AD&D Plan - __________
Supplemental Dependent Life/AD&D Plan - __________

(Please see next column for BASIC Life/AD&D)

Basic Life / AD&D Plan Options:

Must also complete Request to Participate Form

Employee Life:  ☐ Yes  ☐ No

Refer to Minimum/Maximum Table Below

☐ PLAN A - $___________

Flat amount for each employee
(Please see Min/Max Table below)

☐ PLAN B - $___________

Flat amount based on class of employee**

**Attach listing of employees by class, indicating amount of coverage to be provided to each class.

☐ PLAN C - ________X salary for all employees

(1X salary or 2X salary)

Dependent Life:  ☐ Yes  ☐ No

☐ Option 1  ☐ Option 2  ☐ Option 3

Spouse  $7,500  $4,000  $2,000
Children*  $3,750  $2,000  $1,000

*14 days to age 19; student definition same as medical

Coverage provided by UnitedHealthcare Insurance Company

Life/AD&D Minimum/Maximum Table

<table>
<thead>
<tr>
<th># of Lives</th>
<th>2-5</th>
<th>6-19</th>
<th>20-50</th>
<th>51-99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Maximum</td>
<td>$50,000</td>
<td>$175,000</td>
<td>$250,000</td>
<td>$350,000</td>
</tr>
<tr>
<td>Guarantee Issue</td>
<td>$25,000</td>
<td>$50,000</td>
<td>$100,000</td>
<td>$175,000</td>
</tr>
</tbody>
</table>

Dental Waiting Period Waivers:
In order for this waiver to be administered we must have documentation that shows there was coverage in effect 12 months prior to their effective date of coverage. There are many different forms of documentation we can accept. A Certificate of Coverage, Plan Summary Document, a member’s EOB, or a renewal from the prior carrier.

By signing below, the undersigned agrees that the above selected benefits will be provided for the members of the employer group. Such selection(s) will be incorporated into the Group Policy and Certificate, which are the governing documents. In addition, I verify that all employees applying for or waiving coverage are eligible to do so. Preliminary rates will be adjusted to reflect actual enrollment and underwriting risk assignment for final rates. Rates are not final until the Final Confirmation Form is returned.

Group Administrator __________________________ (Signature) __________________________ Date

Do not cancel your existing coverage until you receive written notification of approval.