

Individual Application

Insured by United HealthCare Insurance Company



To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. Include a deposit check in the amount of the estimated first month's premium; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

A. General Information

Requested Effective Date _____

Legal Name (Last)		(First)	(Middle Initial)	
Street Address			Social Security Number	
City		State	Zip Code	County
Telephone	Fax	Email Address		
Billing Address (if different)				

B. Affirmation

In order to be eligible for Cover Florida, please affirm the following are true:

- Applicant is not eligible for coverage through a public health insurance program, such as Medicare, Medicaid or Kidcare, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements.
- Applicant has not had been covered by any medical insurance program at any time during the past six months.

OR if Applicant has lost coverage in the past 6 months indicate reason below:

- Loss of a job that provided an employer-sponsored health benefit plan
- Exhaustion of coverage that was continued under COBRA or continuation-of-coverage requirements under s. 627.6692, Florida Statutes
- Reaching the limiting age under the policy
- Death of, or divorce from, a spouse who was provided an employer-sponsored health benefit plan.

For applicants who had prior coverage, please attach a Certificate of Credible Coverage from your prior carrier in order to expedite pre-existing condition exclusion processing.

C. Product Type

- Cover Florida Standard Cover Florida Standard Plus

D. Important Information

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Member Handbook or other materials do not answer your questions. Further information is available at www.coverflorida-uhc.com or the at toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

E. Agent Information

Agent Name Holly A. Hail		Agency Peoples Health Insurance, LLC		Agent Code/Tax ID Number 76-0755601	
Printed Agent Name	Email Address hhail@peopleshealthinsurance.com	Social Security #		Phone Number 800-300-6167 727-531-8383	Date
Rep Name Holly A. Hail				Rep #	
Commissions payable to Peoples Health Insurance, LLC					
Agent Signature			Florida License ID# E120152		

The Enrolling Entity certifies that the information provided above is complete and accurate. The Enrolling Entity shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of the applicant or their dependents.

Upon receipt by UnitedHealthcare and Affiliates of this signed application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding agent compensation:

We pay agents compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total agent compensation paid. It is our policy not to pay commissions to agents with respect to a product for which the customer is also paying the agent a commission or other fee. Please note we also make payments from time to time to agents for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Agent compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that agents properly disclose their compensation arrangements to their customers, but we cannot guarantee the agent's compliance. For general information on our agent payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to <http://www.uhc.com> and click on the dropdown box for employers under "View Our Programs - Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your agent.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

F. Signature (Form must be signed)

Date	Applicant Signature for all applying and waiving	Spouse Signature (if applying for coverage)
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Primary Language Spoken English Spanish Other _____

I confirm that the information I have provided on this form is complete and accurate. I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

COVER FLORIDA IS A LIMITED HEALTH BENEFIT PROGRAM WHICH DOES NOT ENCOMPASS ALL REQUIRED BENEFIT MANDATES AS PROVIDED FOR UNDER FLORIDA LAW. PLEASE CONSIDER YOUR OTHER COVERAGE OPTIONS CAREFULLY BEFORE ENROLLING IN THIS PROGRAM.



Individual Coverage Enrollment Application/ Change/Cancellation Request

- | | |
|---------------------------------|---|
| <input type="checkbox"/> Enroll | <input type="checkbox"/> Address Change |
| <input type="checkbox"/> Cancel | <input type="checkbox"/> Name Change |
| <input type="checkbox"/> Change | Date of Change ___/___/___ |

To Be Completed By Applicant

Legal Name _____	Group # _____	Department # _____
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<input type="checkbox"/> New Enrollment/Additions: (Check one) <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Court ordered dependent <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Cancellations: Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel all listed below – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Obtained other medical coverage <input type="checkbox"/> Other (describe) _____
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Signature _____ Date _____

A. Enrollee Information

Phone Number _____

Last Name	First Name	MI	Social Security Number	Home Phone	Work Phone
Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Optional Physician* (First & Last Name) / Physician's ID Number
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Race – Check all that apply (Optional)** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other—Please specify _____
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*IMPORTANT: Not required for Cover Florida.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name	First Name	MI	Sex	Relationship**	Birthdate	Full Time Student***	Physician* (First and Last Name) Physician's ID Number
<input type="checkbox"/> Enroll <input type="checkbox"/> Change				M F	Spouse			
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Cancel ___ / ____ (mm/yy)
<input type="checkbox"/> Enroll <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Cancel ___ / ____ (mm/yy)
<input type="checkbox"/> Enroll <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Cancel ___ / ____ (mm/yy)
<input type="checkbox"/> Enroll <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Cancel ___ / ____ (mm/yy)
<input type="checkbox"/> Enroll <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Cancel ___ / ____ (mm/yy)

* IMPORTANT: Not required for Cover Florida.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Please see employer representative for student status qualifications.

**** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

D. Affirmation**This section must be completed. (Attach sheet if necessary.)**

In order to be eligible for Cover Florida, please affirm the following is true:

- Enrollee is not eligible for coverage through a public health insurance program, such as Medicare, Medicaid or Kidcare, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements.
- Enrollee has not had been covered by any medical insurance program at any time during the past six months.

or if Enrollee has lost coverage in the past 6 months indicate reason below:

- Loss of a job that provided an employer-sponsored health benefit plan
- Exhaustion of coverage that was continued under COBRA or continuation-of-coverage requirements under s. 627.6692, Florida Statutes;
- Reaching the limiting age under the policy
- Death of, or divorce from, a spouse who was provided an employer-sponsored health benefit plan.

For eligible employees who had prior coverage, please attach a Certificate of Credible Coverage from your prior carrier in order to expedite pre-existing condition exclusion processing.

E. Signature

I confirm that the information I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Applicant Signature for all applying and waiving	Spouse Signature (if applying for coverage)
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IMPORTANT INFORMATION

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 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
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5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I request the indicated group coverage for myself and, if the plan provides, for my dependents. I understand I am required to pay my monthly premiums in order to receive coverage.

I authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I agree that this authorization is valid for 30 months from the date below. I know that I have the right to ask for and to receive a copy of this authorization.

I have not given the agent or any other persons any health information not included on the Request for Coverage. I understand that the HMO/insurance company(ies) is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

COVER FLORIDA IS A LIMITED HEALTH BENEFIT PROGRAM WHICH DOES NOT ENCOMPASS ALL REQUIRED BENEFIT MANDATES AS PROVIDED FOR UNDER FLORIDA LAW. PLEASE CONSIDER YOUR OTHER COVERAGE OPTIONS CAREFULLY BEFORE ENROLLING IN THIS PROGRAM.