

Request for Portability of Critical Illness 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
 The Employee or applicable Dependent will not be eligible to port the Critical Illness coverage if the Employee has not been insured under the policy for at least 6 months (time limit may vary by state). Refer to your COC for other eligibility requirements.

Sections A, B and C to be completed by Employer

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: (____) _____-_____
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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):

Employee
 Employee and Dependent Spouse
 Employee and All Dependents
 Employee and Dependent Children

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

F. Quarterly or Annual Premium Calculation

Please choose either Quarterly or Annual billing: Quarterly or Annual

Quarterly Premium Calculations	Annual Premium Calculations
Employee's quarterly premium is calculated: (a.) Monthly premium x 1.35 = \$ _____ (b.) Multiply (a.) x 3 = \$ _____.**	Employee's annual premium is calculated: (a.) Monthly premium x 1.35 \$ _____ (b.) Multiply (a.) x 12 = \$ _____.**
**This is your new Quarterly Premium	**This is your new Annual Premium

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 Critical Illness 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
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