# Request for Portability of Critical Illness Insurance*

UnitedHealthcare®

**This portability request form should be used with plans that may include Child Critical Illness, Additional Critical Illness, or Partial Benefit Critical Illness plan options.**

***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

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## 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:<br><br>Monthly premium x 3 = $_____**<br><br>**This is your new Quarterly Premium for the first 12 Months of Portability. See NOTE below. | Employee's quarterly premium is calculated:<br><br>Monthly premium x 12 = $_____**<br><br>**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 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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