IBC Advanced Alloys

January 11th, 2021

To All IBC Employees:

2021 OPEN ENROLLMENT FOR VOLUNTARY DENTAL BENEFITS

2021 IBC Voluntary Dental Benefits: UnitedHealthcare has been selected to be the Provider for the Voluntary Dental Benefit coverage.

IN-NETWORK AND NON-NETWORK PAYS THE SAME!! UnitedHealthcare provides the same percentage of reimbursement for Out-of-Network dentists as In-Network. Please see the attached UnitedHealthcare Dental Service Plan for additional information on the Plan's coverages.

WEEKLY PREMIUMS

2021 VOLUNTARY DENTAL WEEKLY PREMIUM RATES	EMPLOYEE ONLY	EMPLOYEE & SPOUSE RATES	EMPLOYEE & CHILD(REN) RATES	EMPLOYEE & FAMILY RATES
UnitedHealthcare offers a $1500 Annual with $50 Deductible per Individual (Deductible Does Not Apply To Preventative Care, Only Basic and Major Procedures)	$9.57	$19.13	$22.69	$34.01

2021 OPEN ENROLLMENT INSTRUCTIONS

Voluntary Dental Plan: Employees who are currently participating in the Voluntary Dental Plan and want to continue, or Employees who would like to enroll in the Voluntary Dental Plan for 2021 will need to complete Sections A, B, C, D and G of the UnitedHealthcare Employee Enrollment Form.

Complete and sign enrollment forms for Voluntary Dental Benefits and return to Human Resources in Franklin by Monday, January 18th, 2021

If you have any questions, please do not hesitate to contact Claudia Niehaus, Safety/HR Manager at cniehaus@ibcadvancedalloys.com or by phone at (317) 738-2558.

Copper Alloys Division
401 Arvin Road
Franklin, IN 46131
Phone: (317) 738-2558
Fax: (317) 738-2685

Engineered Materials Division
55 Jonspin Road
Wilmington, MA 01877
Phone: (978) 284-8900
Fax: (978) 284-8955

UnitedHealthcare Dental®
Consumer MaxMultiplier Voluntary Options PPO/covered dental services

dental plan
P3388

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	None	None
Family Annual Deductible	$150	$150	None	None
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per calendar year	$1500 per person per calendar year	$1500 per person per lifetime	$1500 per person per lifetime

Annual deductible applies to preventive and diagnostic services	No
Annual deductible applies to orthodontic services	No
Waiting Period	No waiting period
Orthodontic eligibility requirement	Children under age 19

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES			
Periodic Oral Examinations	100%	100%	Limited to 2 times per consecutive 12 months.
Bite-Wing X-rays	100%	100%	One series of films per calendar year.
Complete Series or Panorex X-rays	100%	100%	Limited to one time per consecutive 36 months.
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
BASIC DENTAL SERVICES			
Space Maintainers	80%	80%	For covered persons under the age of 16 years, once per lifetime.
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
General Anesthesia	80%	80%	When medically necessary.
Amalgam Restorations (Fillings)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
Composite Restorations (Fillings)	80%	80%	Multiple restorations on one surface will be treated as a single filling. For anterior teeth only.
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
Root Canal Treatment	80%	80%	
Scaling and Root Planing	80%	80%	Limited to one time per quadrant per consecutive 24 months.
Periodontal Surgery	80%	80%	Limited to once every consecutive 36 months per surgical area.
Periodontal Maintenance	80%	80%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
MAJOR DENTAL SERVICES			
Crowns, Inlays, and Onlays	50%	50%	Limited to one time per tooth per consecutive 60 months.
Fixed Bridges	50%	50%	Once per tooth per consecutive 60 months. Alternate benefits for a partial denture may be applied.
Full Dentures	50%	50%	Once per consecutive 60 months. No allowance for overdentures or customized dentures.
Partial Dentures	50%	50%	Once per consecutive 60 months. No allowance for precision or semi-precision attachments.
Recement Bridges, Crowns, Inlays	50%	50%	
Relining and Rebasing Dentures	50%	50%	Limited to one time every consecutive 12 months, and limited to relining done more than 6 months after the initial insertions.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	50%	Limited to repairs or adjustments performed more than 12 months after the initial insertion.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with initial payment at banding of 20% and remaining payment spread equally over the course of treatment.

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

**Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $200; please consult your dentist.

*** The network percentage of benefits is based on the discounted fee negotiated with the provider.

**** The non-network percentage of benefits is based on the schedule of reasonable and customary charges in the geographic area in which the expenses are incurred.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Voluntary Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or United HealthCare Services, Inc.

UnitedHealthcare/dental exclusions and limitations

GENERAL LIMITATIONS

ORAL EXAMINATIONS Covered as a separate benefit only if no other service was performed during the visit other than prophylaxis and X-rays. Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Panorex Radiographs if taken for diagnosis of third molars, cysts, or neoplasms.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

DIAGNOSTIC CASTS Limited to one time per consecutive 24 months.

FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.

RESTORATIONS Multiple restorations on one surface will be treated as a single filling. Composite restorations limited to anterior teeth only.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

INLAYS AND ONLAYS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.

FULL DENTURES Limited to once every consecutive 60 months. No additional allowances for overdentures or customized dentures.

PARTIAL DENTURES Limited to once every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining or rebasing performed more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Covered only if prescribed to control habitual grinding, and limited to one guard every consecutive 36 months.

FULL MOUTH DEBRIDEMENT Limited to once every consecutive 36 months.

GENERAL ANESTHESIA Covered only where medically necessary.

OSSEOUS GRAFTS With or without resorbable GTR membrane replacement, are limited to once every consecutive 36 months per quadrant or surgical site.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to once every consecutive 36 months, per surgical area. This includes gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, pedicle grafts, and free soft tissue grafts.

REPLACEMENT OF FULL DENTURES, PARTIAL DENTURES, BRIDGES, OR CROWNS Replacement of complete or partial dentures, both fixed and removable, or crowns, previously submitted for payment under this Plan is limited to once every consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Dental Services provided in a foreign country, unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.
15. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
20. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
23. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
24. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
25. Acupuncture; acupressure and other forms of alternative treatment.
26. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
27. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

(DO NOT STAPLE)

Employee Enrollment Form
Indiana

UnitedHealthcare®

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer | **Requested Effective Date of Coverage/Date of Change** / /

Group Name | Policy Number

Date of Hire / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
- ☐ New Group Plan
- ☐ New Hire
- ☐ Life Event/Date_____
- ☐ Annual Open Enrollment
- ☐ Status Change_____
- ☐ Dependent Add/Delete
- ☐ Change Name/Address
- ☐ Late Enrollee
- ☐ Part time to Full time
- ☐ Waiving Coverage
- ☐ Termination
- ☐ Other_____

Employee Type (Check all that apply)
- ☐ Active ☐ COBRA ☐ State Continuation
  - Start dt ___/___/___
  - End dt___/___/___
- ☐ Hourly ☐ Salary
- ☐ Union ☐ Non-Union ☐ Retired
- ☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and B.

Last Name | First Name | MI | Social Security Number ___-___-____

Address | Apt # | City | State | Zip Code | Home/Cell Phone

Date of Birth / / | Gender ☐ M ☐ F | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Language Preference, if not English | Work Phone

Email Address

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name _____

Address _____

ID# _____

Primary Care Dentist[3]

Dentist First & Last Name _____

ID# _____

Existing Patient? ☐ Yes ☐ No

B. Waiver of Coverage

I decline all coverage for:
- ☐ Myself
- ☐ Spouse
- ☐ Dependent Children
- ☐ Myself and all dependents

Declining coverage due to existence of other coverage:
- ☐ Spouse's Employer's Plan
- ☐ Individual Plan
- ☐ Covered by Medicare
- ☐ Medicaid
- ☐ COBRA from Prior Employer
- ☐ VA Eligibility
- ☐ Tri-Care
- ☐ I (we) have no other coverage at this time
- ☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date | Employee Signature if waiving all coverage

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or All Savers Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name ______________________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Spouse	Social Security Number | | —| | —| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# __ __ __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | —| | —| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# __ __ __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | —| | —| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# __ __ __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | —| | —| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# __ __ __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

Relationship[4]	Last Name	First Name	MI	Sex ☐ M ☐ F	Date of Birth / /
Dependent	Social Security Number | | —| | —| | | |	Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No			

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# __ __ __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[5] ☐ Yes ☐ No

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Employee Name _____

D. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Employee	☐ N/A	☐	☐ N/A	☐ $ N/A	☐ $ N/A
Spouse	☐	☐	☐	☐ $	☐ $
Dependent	☐	☐	☐	☐ $	☐ $

Person	STD	LTD
Employee	☐ N/A	☐ N/A

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)	Relationship
Primary N/A	N/A
Secondary	

E. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section)

Prior medical carrier name N/A Effective date ___ ___ ___ End date ___ ___ ___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

F. Other Medical Coverage Information

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

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier N/A

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name: N/A		N/A	N/A	
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date N/A ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date ___ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date ___ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work
Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___ ___ ___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date N/A ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date ___ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date ___ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.
** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

G. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") 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, HIV/AIDS, 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 that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires 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 joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare 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.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No