

Enrollment Periods and Effective Dates

There are two types of enrollment periods during which you may apply for our plans - Open Enrollment and Special Enrollment. The charts below explain the possible effective dates of coverage.

Open Enrollment – the set annual time period when you apply for coverage.

Enrollment Period	Application Received	Effective Date*
October 1, 2013 – December 15, 2013	October 1, 2013 – December 15, 2013	January 1, 2014
December 16, 2013 – March 31, 2014	Day 1 – 15 of the month -----	1st day of the following month -----
	Day 16 – last day of the month	1st day of the 2nd following month

Special Enrollment – the time period when you can apply for coverage if you experience a qualifying event.

Event	Enrollment Period	Application Received	Effective Date**
Loss of minimum essential coverage (does not include failure to pay premium)	Within 60 days following loss of coverage	Within 60 days following loss of coverage	1st day of the month following the event
New dependent such as: birth, adoption, or placement for adoption	Within 60 days following the event	Within 60 days following the event	Date of event
Permanent move to Michigan from another state	Within 60 days following the move	Day 1 – 15 of the month -----	1st day of the month following receipt of the application -----
		Day 16 – last day of the month	1st day of the 2nd month following receipt of the application
Marriage or divorce	Within 60 days following the event	Within 60 days following the event	1st day of the month following the event

* Open Enrollment Effective Date is dependent upon timely receipt of premium due. We must receive all premium before the coverage can be effective. Coverage can only be effective on the first day of the month.

** Special Enrollment Effective Date is dependent upon timely receipt of premium due. We must receive all premium before the last day of the Enrollment Period. Coverage can only be effective on the first day of the month, unless a “New dependent.”

PLEASE RETURN APPLICATION FOR SUBMISSION VIA:

Email: healthquotes@northvilleinsurance.com

FAX: 248.374.3239

Mail:

Blue Sky Insurance Agency
 324 E Main St
 Northville, MI 48167



FACT Membership Enrollment Information

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers.

FACT is an independent consumer association whose members benefit from the “pooling” of resources. Benefits range from medical savings to consumer service discounts. If you’re not already a member, you are required to join FACT.

Important Information for Submitting Your Completed Application

- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- Review your application to be sure it is completed.
- Social Security or TIN numbers are required by the federal government to implement the Affordable Care Act.
- Include all requested details and explanations. If you need to include additional information, attach an extra sheet of paper. Include your signature and date on the extra sheet.
- Sign and date your application and related forms. Signature is also required for your spouse.
- Do not cancel any existing coverage you might have until you are notified that your application has been approved.
- Read the applicable product brochure(s).
- Brokers must be appointed with UnitedHealthcare Life Insurance Company in the state where an application is signed and the state where the primary applicant resides.
- **Mail the Application and Related Forms and be sure to include the following:**
 - Health insurance quote.
 - Initial payment:
 - Check made payable to “FACT”;
 - EFT authorization (if paying via EFT); or
 - Credit card authorization (if paying via credit card).

Mail to: UnitedHealthcare Life Insurance Company
HEALTH APPLICATION
PO Box 31370
Salt Lake City, UT 84131-0370

Please Note:

- You will be notified of the actions taken within 45 days after the date of application, or be given the reason for delay.
- There is no coverage until approved in writing by UnitedHealthcare Life Insurance Company.

Citizenship - See Question 4 on page 2 of the application.

If any applicant is not a United States citizen or national, but maintains eligible immigration status, you are requested to provide documentation. Below is the list of acceptable Document Types.

- a. Reentry Permit (I-327)
- b. Permanent Resident Card (Green Card, I-551)
- c. Refugee Travel Document (I-571)
- d. Employment Authorization Card (I-766)
- e. Machine Readable Immigrant Visa (with temporary I-551 language)
- f. Temporary I-551 Stamp (on passport or I-94, I-94A)
- g. Arrival/Departure Record (I-94, I-94A) Issued by U.S. Citizenship and Immigration Services
- h. Arrival/Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection
- i. Arrival/Departure Record in unexpired foreign passport (I-94)
- j. Unexpired foreign passport
- k. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- l. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- m. Notice of Action
 - a. Alien Number
 - b. I-94 Number (I-797)

UnitedHealthcare Life Insurance Company is the underwriter and administrator of these plans.

I hereby enroll for membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues, I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) some benefits may have a delayed effective date; (d) my membership will become effective on the day this enrollment form is dated and signed; (e) I am eligible to apply for association group insurance; and (f) I authorize the release of the following information to FACT: my name, address, date of birth, certificate and phone numbers, application date, and email address listed on the UnitedHealthcare Life Insurance Company Application for Insurance. NOTE: Accident Insurance is included in your FACT membership and you will have an opportunity to name your beneficiary(ies) by mail or on the FACT website.

Member's Signature X _____ Date X _____

FACT ENFO 1013 _____ If you wish to apply for association group health insurance, please complete the application below.

SECTION 1 UNITEDHEALTHCARE LIFE INSURANCE COMPANY – Application for Insurance

Applicant(s) Information - Must Be Completed by the Applicant

Please Print In Black Ink

1. REASON FOR APPLICATION:

New Application Add a dependent

ID Number _____
(for additions)

2. PRIMARY APPLICANT'S INFORMATION:

a. Name (Last, First, M.I.): _____

b. Mailing Address _____
Street (Include Apt.)

City _____ State _____ ZIP _____

c. A physical address is required if different than your mailing address. PO Boxes are not accepted as a physical address.

Physical Address _____
Street (Include Apt.)

City _____ State _____ ZIP _____

d. County of Residence _____

e. Phone Numbers (Home) _____ (Other) _____
Best number and time to call _____ Email Address _____

f. Payor (If not You) Name _____ Email Address _____
Street _____ City _____ State _____ ZIP _____

g. Marital Status: Married Single

3. APPLICANTS FOR COVERAGE:

Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date
<input type="checkbox"/> Male <input type="checkbox"/> Female	a. Primary (You)	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	b. Spouse	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	c. Child	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	d. Child	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	e. Child	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	f. Child	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	g. Child	_____	_____

If you need to list additional dependents, please use lined paper, sign and date it, and check this box.



4. Is any applicant not a United States citizen or national? YES NO

(If yes, indicate who below and provide the requested information for that person.)

Applicant (same as in Question 3)	Does this person have eligible immigration status?	Document Type	ID Number	Has this person lived in the U.S. since 1996?
<input type="checkbox"/> a. Primary	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> b. Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> c. Child	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> d. Child	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> e. Child	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> f. Child	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> g. Child	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

5. In the last 6 months, has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) 4 or more times per week on average, excluding religious or ceremonial uses? YES NO

(If yes, indicate who.)

a. Primary b. Spouse c. Child d. Child e. Child f. Child g. Child

SECTION 2

Product Selection & Billing (or attach a health insurance quote). Complete for new applications only.

Effective Date ___/___/___	FACT Membership Dues \$ _____ Base Premium Amount (includes taxes and fees) + _____
OPTIONAL BENEFITS — See current brochure and inserts for availability	
Copay Plans <input type="checkbox"/> Bronze Copay Select SM <input type="checkbox"/> Silver Copay Select SM 1 <input type="checkbox"/> Silver Copay Select SM 2 <input type="checkbox"/> Silver Copay Select SM 3 <input type="checkbox"/> Gold Copay Select SM 1 <input type="checkbox"/> Gold Copay Select SM 2 <input type="checkbox"/> Platinum Copay Select SM HSA Plans <input type="checkbox"/> Bronze HSA 100® <input type="checkbox"/> Silver HSA 100® Catastrophic Plan <input type="checkbox"/> Select Saver SM (Must provide a copy of a Certificate of Exemption for each applicant who is age 30 or older.)	<input type="checkbox"/> Supplemental Accident <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 ¹ <input type="checkbox"/> \$2,500 ¹ <input type="checkbox"/> \$3,000 ¹ <input type="checkbox"/> \$3,500 ¹ <input type="checkbox"/> \$3,650 ¹ <input type="checkbox"/> \$4,000 ^{1,2} <input type="checkbox"/> \$5,000 ^{1,2} <input type="checkbox"/> \$5,500 ^{1,2} <input type="checkbox"/> \$6,000 ^{1,2} <input type="checkbox"/> \$6,350 ^{1,2} (¹ Not available with Platinum Copay Select SM) (² Not available with Silver HSA 100®) + _____ Optional <input type="checkbox"/> Accidental Death (Primary) + _____ Optional <input type="checkbox"/> Accidental Death (Spouse) + _____ Optional <input type="checkbox"/> UnitedHealthcare Vision (for adults) + _____ Optional <input type="checkbox"/> HSA Deposit + _____
Total Monthly Payment (Payable to FACT) = \$ _____	

If Quarterly, Total Monthly Payment x 3 (Payable to FACT) = \$ _____

6. Payment

Initial Payment with Application: Check EFT Credit Card

Ongoing Payments: Monthly EFT Direct Bill

Quarterly Direct Bill

IMPORTANT:

- Premium will be verified and may be adjusted up or down during the processing of your application.
- Checks will be deposited upon receipt.
- EFT (personal account only) and Credit Card payments will be collected upon approval of application.

SECTION 3

Special Enrollment

Complete only if applying outside the open enrollment time frame. You must provide written proof of eligibility for any of the reasons marked in question 7. Submit copies of documents supporting the occurrence of the event(s).

7. You may be eligible for health insurance coverage under Special Enrollment Periods if at least one of the following events occurred in the last 60 days: (Mark all that may apply, indicate to whom they apply, and answer the corresponding questions.)

- a. Loss of health insurance. Which applicant(s)? _____
 - i. Did the applicant lose health insurance because of not paying premium? YES NO
 - ii. When did the applicant lose health insurance? (MM/DD/YY) ___/___/___
 - iii. Type of insurance coverage lost:
 - Group — Provide employer's information

Employer's Name	Telephone Number								
	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>								

Street	City	State	ZIP
<input type="checkbox"/> Individual <input type="checkbox"/> COBRA Effective date of COBRA ___/___/___ Date COBRA Terminated ___/___/___ <input type="checkbox"/> Short Term <input type="checkbox"/> Medicaid <input type="checkbox"/> Other (please specify) _____			

- b. Married. Which applicant(s)? _____

- i. When did the applicant get married? (MM/DD/YY) ___/___/___

- c. Birth, adoption, or placement for adoption. Which applicant(s)? _____

- i. When was the applicant born, adopted, or placed for adoption? (MM/DD/YY) ___/___/___

- d. Released from incarceration (jail or prison). Which applicant(s)? _____

- i. When was the applicant released? (MM/DD/YY) ___/___/___

- e. Moved to a different state. Which applicant(s)? _____

- i. When did the applicant move? (MM/DD/YY) ___/___/___

- ii. What is the address the applicant moved from?

Street	City	State	ZIP								
			<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>								

SECTION 4

Optional Accidental Death Insurance Coverage (Not available for children.)

Complete this section only if applying for optional underwritten accidental death insurance coverage for the primary applicant and/or spouse.

- 8. In the last 2 years, did any applicant engage in, or in the next 12 months, does any applicant plan to engage in, any of the avocations listed below:**
- | | YES | NO |
|---|--------------------------|--------------------------|
| a. Motorized racing (automobile, motorcycle, water-craft, snowmobile, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Competitive skiing or snowboarding? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Skydiving (more than once per year)? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Skin or scuba diving (deeper than 60 feet and more than once per year)? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hang gliding? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Student pilot (airplane, helicopter, glider, ultra-light)? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Pilot or crew member of an aircraft (commercial, private Cessna, hot air balloon)? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Driving a motorcycle? | <input type="checkbox"/> | <input type="checkbox"/> |
- 9. In the last 5 years, was any applicant convicted of a felony, DUI, or had his/her driver's license suspended or revoked?** YES NO

For each Yes answer in Questions 8 and 9, provide the applicant's name. If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box.

Question Number _____ Applicant _____	Question Number _____ Applicant _____
Question Number _____ Applicant _____	Question Number _____ Applicant _____
Question Number _____ Applicant _____	Question Number _____ Applicant _____
Question Number _____ Applicant _____	Question Number _____ Applicant _____

SECTION 5

Statement of Understanding —

Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded. **I understand and agree that:**

- (1) This application and the initial payment do not give me immediate coverage.
 - (2) I should not terminate existing coverage until I have accepted the UnitedHealthcare Life Insurance Company coverage.
 - (3) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**
 - (4) This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.
 - (5) The broker may only submit the application and initial payment, and may not promise me coverage, modify UnitedHealthcare Life's underwriting policy or terms of coverage, or change or waive any right or requirement.
 - (6) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.
 - (7) If UnitedHealthcare Life rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by UnitedHealthcare Life does not constitute approval of my application or create UnitedHealthcare Life coverage.
 - (8) I must select a primary care physician. If I do not select a primary care physician, one will be assigned to me. Benefits may not be payable if I see a specialist without a referral from my primary care physician.
 - (9) The policy/certificate requires some medical services to be authorized by UnitedHealthcare Life or its representative before the services are provided, and benefits for these services may be reduced if the prior authorization is not obtained.
 - (10) The policy/certificate does not cover the charges for services received from a non-network provider, except for emergencies.
- I have received a Notice of Information Practices and a Conditions Prior to Coverage.

X _____ / /
Primary Applicant (You) Date

X _____
Spouse (if to be covered)

X _____
Parent/Guardian (if you are a minor) Relationship

Primary Care Physician Selection: Please select a Primary Care Physician (PCP) from our network who is in your state of residence. If no PCP is listed, we will assign one to you. See our Physician Listing at UHCindividual.com/doctor.

	Physician's Name	Phone Number	Office Address	City	State	ZIP
a. Primary (You)					MI	
b. Spouse					MI	
c. Child					MI	
d. Child					MI	
e. Child					MI	
f. Child					MI	
g. Child					MI	

If you need to list Primary Care Physicians for additional dependents, please use lined paper, sign and date it, and check this box.

Broker Statement: Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____ X _____
 Signature of Licensed Broker Print Full Name

 Broker Number

Authorization to Obtain and Disclose Nonmedical Information

I authorize UnitedHealthcare Life Insurance Company to obtain information that they need to verify my application for insurance. Any employer, insurance company, government agency, or consumer-reporting agency having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to UnitedHealthcare Life Insurance Company.

I (we) have received UnitedHealthcare Life Insurance Company's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UnitedHealthcare Life Insurance Company. I (we) may request revocation of this authorization by writing to UnitedHealthcare Life Insurance Company, as explained in UnitedHealthcare Life Insurance Company's Notice of Information Practices. UnitedHealthcare Life Insurance Company may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

ADNI-UL-1013

I have read the above: Authorization to Obtain and Disclose Nonmedical Information.

X _____ / / X _____
 Primary Applicant (You) Date Spouse (if to be covered)
 X _____
 Parent/Guardian (if you are a minor) Relationship

Health Savings Account (HSA) application — Only if opening an HSA with Optum Bank

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with Optum Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by Optum Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with Optum Bank's Privacy Policy and Schedule of Fees.
- I authorize Optum Bank to provide information about my HSA, including my account number, to UnitedHealthcare Life Insurance Company, and those acting on behalf of UnitedHealthcare Life Insurance Company or Optum Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that UnitedHealthcare Life Insurance Company and all others acting on behalf of UnitedHealthcare Life Insurance Company, may provide information on my behalf to establish and maintain my HSA and authorize UnitedHealthcare Life Insurance Company and its designee to take such action deemed necessary and appropriate by UnitedHealthcare Life Insurance Company to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Optum Bank if I wish to have statements mailed to my home address.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User debit card, I hereby request Optum Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I authorize Optum Bank to share information about my HSA with the Authorized User named, and to allow any account transactions made by such Authorized User.
- I certify that the information provided in this application is true and complete.

X _____

Signature of Primary Applicant

Primary Applicant's Social Security No.

Applicant's Spouse Social Security No.

Per the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)

Authorized User's First Name Middle Initial

Authorized User's Last Name

Authorized User's Date of Birth

Authorized User's Social Security No.

HSA-UL-1013

Electronic Funds Transfer (EFT) Authorization — Only if paying EFT

I (we) hereby authorize FACT or UnitedHealthcare Life Insurance Company to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

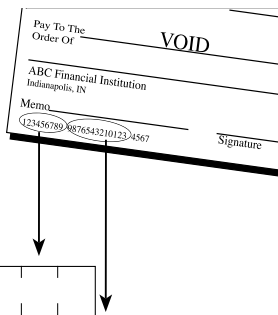
I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of Account: Checking Savings

Nine-digit Routing No.

Account No.

EFT-UL-1013



Financial Institution's Name

Address

City, State, ZIP

Draft On

Day

Date Signed

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X _____

Authorized Account Signature

Email Address

Initial Payment Credit Card Authorization

I authorize FACT or UnitedHealthcare Life Insurance Company to bill my American Express/MasterCard/Visa account for the Initial Payment. **If quarterly billing requested, the Initial Payment will be for three months plus any one-time costs.**

Type of Card: MasterCard Visa American Express

Exp. Date:
Month Year

Billing ZIP Code:

CC-UL-1013

Card Number:

X _____

Signature of Authorized User

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.