



I authorize United HealthCare Insurance Company and their affiliates (collectively, "UnitedHealthcare") to use and disclose any personal information concerning me and/or my dependents that is contained on any application for health insurance coverage that I have completed within 90 days before or after the date of this authorization, including any individually identifiable health information contained in these applications. I authorize any healthcare provider, pharmacy benefit manager, other insurer or re-insurer, hospital, clinic or other medical facility, healthcare clearinghouse, and any other affiliates, representatives or business associates, to disclose my information to The Company and Affiliates. I understand the purpose of the disclosure and use of my information is to allow The Company and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign may, however, affect my ability to enroll in a UnitedHealthcare health plan or my eligibility to receive benefits if permitted by HIPAA or any other applicable state or federal law.

I understand that I may revoke this authorization at any time by notifying UnitedHealthcare in writing at 5901 Lincoln Drive, Mail Route MN012-N123, Edina, MN 55436 except to the extent that action has already been taken in reliance on this authorization. I also understand that I have a right to ask for and receive a copy of this authorization.

I further understand that, should my employer choose UnitedHealthcare as its health insurance provider, I will be required to complete a UnitedHealthcare health and life insurance application prior to enrollment in a UnitedHealthcare health plan. UnitedHealthcare reserves the right to change the schedule of premiums applicable to your employer group based on updated, revised or additional information provided in such application.

Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

SSN: \_\_\_\_\_ SSN: \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_  
(If applicable and available)

Date: \_\_\_\_\_ Date: \_\_\_\_\_