

Product and Benefit Selection Form for California Small Business



Effective October 1, 2008

General Information

Group Name _____

Agent _____

1. Please Indicate Medical Plan Selection

Select up to a maximum of two plans. HSA plans may not be offered alongside HRA plans. Plans indicated with an asterisk (*) are only available on a stand-alone basis.

Would you like to select a Calendar Year or Policy Year plan? Calendar Year Policy Year

UnitedHealthcare Choice Plus DefinitySM Health Savings Account (HSA) Plans

- 2000/100% Plan 7A-T¹
- 1500/80% Plan U1-O¹
- 2850/80% Plan 6C-K¹
- 2850/80% Plan 6C-L
- 3500/70% Plan 6C-J¹
- 3000/70% Plan 6C-I

¹Annual family deductible does not include an embedded individual deductible.

UnitedHealthcare Choice Plus Consumer (HRA) Plans

- 1500/100% Plan 7A-L
- 2000/100% Plan 7A-M
- 1500/80% Plan 6C-H
- 2500/80% Plan S1-Y
- 3000/70% Plan 6C-G

UnitedHealthcare Choice Plus Traditional with Deductible Plans

- 20/250/90% Plan 6C-M
- 35/500/80% Plan 6C-D
- 30/500/70% Plan 6C-B

UnitedHealthcare Choice Plus Balanced 100 Plan

- 30/3000/100% Plan 6C-X Value Plan 6C-O

UnitedHealthcare Choice Plus Balanced Plans

- 25/1000/80% Plan 6C-W Value Plan 6C-P
- 25/2500/80% Plan 6C-V Value Plan 6C-Q
- 35/1000/70% Plan 6C-C Value Plan 6C-R
- 40/1500/70% Plan 6C-F Value Plan 6C-S
- 35/1000/50% Plan 6C-E Value Plan 6C-T
- 35/2000/50% Plan 6C-N Value Plan 6C-U

UnitedHealthcare Non-Differential PPO Plan

- 2000/80% Plan 6H-E*

2. Please Indicate Life and AD&D Plan Selection

Please select one Life and AD&D plan and up to one Dependent Life plan.

Basic Life and AD&D Benefit Amount*

- \$15,000 \$20,000 \$25,000 \$50,000 \$75,000 \$100,000 Other \$ _____

- Tier Class Plan _____ \$ _____
 _____ \$ _____
 _____ \$ _____

- 1 X Annual Salary to \$ _____ 2 X Annual Salary to \$ _____

Dependent Life Benefit Amount

- Spouse \$7,500/Child (14 days+) \$3,750 Spouse \$4,000/Child (14 days+) \$2,000 Spouse \$2,000/Child (14 days+) \$1,000

*Benefit Maximums and Guarantee Issue Maximums

- Groups of 2-5 eligible employees: Maximum \$50,000 / GI \$25,000
- Groups of 6-19 eligible employees: Maximum \$175,000 / GI \$50,000
- Groups of 20-50 eligible employees: Maximum \$250,000 / GI \$100,000

3. Please Indicate Dental and Vision Plan Selection

Select up to a maximum of two HMO and PPO dental plans. Select up to a maximum of one vision plan.

Dual Option

UnitedHealthcare DPPO

- P0061 P3337
- P3340 P3418
- P3499 P4210
- Other: _____

UnitedHealthcare Indemnity

- I1209 I1211
- I1314 I1322
- I0675
- Other: _____

PacificCare DHMO

- D0100 (140), contributory D0101 (142), contributory
- D0102 (144), contributory D0103 (146), contributory
- D0110 (140), voluntary D0111 (142), voluntary
- D0112 (144), voluntary D0113 (146), voluntary
- Other: _____

Pacific Dental Benefits Direct Compensation DHMO

- D0242 (Avalon 200), contributory
- D0309 (Trinity 300), contributory
- D0250 (Carmel 600), contributory
- D0426 (Avalon 200), voluntary
- D0432 (Trinity 300), voluntary
- D0428 (Carmel 600), voluntary
- Other: _____

UnitedHealthcare Vision

- V0009, contributory
- V0005, voluntary
- V0010, contributory
- V0006, voluntary
- V0011, contributory
- V0007, voluntary
- V0012, contributory
- V0008, voluntary
- Other: _____