DUAL OPTION EMPLOYEE PLAN SELECTION FORM.

Instructions:

1. If you've purchased a Dual Option Plan, please use this form to provide us with your employee's choice of medical plans.
2. In the gray box below, please enter the "Renewal Plans" being offered by the employer.
3. Please indicate each employee's renewal plan election by marking an X in the column below his or her elected plan.
4. Sign this form and fax, mail or email it before your renewal date along with the Coverage Request form and rates for each DO Plan.

Renewal Service Center, UnitedHealthcare
5901 Lincoln Drive
MN012-NL14
Edina, MN 55436

Fax (952) 992-4112

e-mail: ARP_Renewals@uhc.com

NOTE: This form SHOULD NOT be used to add employees not previously covered on your plan(s). Please complete an enrollment form for each new employee. The enrollment form can be returned with this form.

Customer Number _____

Renewal Date _____ / _____ /_____

Policy Number(s)

_____, _____

Employer Name

_____

	Employee Last Name	Employee First Name	Member # (Mbr's SSN)	List your selected Dual Option Plans, including Rx coverage Plan 1: _____ Rx: _____	Plan 2: _____ Rx: _____
1	Example Only	John	123456789		

If you would like to discuss additional medical or non-medical plans, please call either our Renewal Service Center at 1 800-477-0001 or your local UnitedHealthcare Account Manager.

Full Legal Name of Employer/Firm _____

Date signed _____ (Month, Day, Year)

Signed By _____ (Employer Signature)