



UnitedHealthcare Georgia Proposal Request Form

Today's Date ____/____/____

Fax to: 1-877-262-6195

Requested Effective Date: ____/____/____

Broker's Name: _____

Broker's Fax #: _____

Please Print

Company Name:	Agency's Name:
Address:	Address:
City State Zip	City State Zip
County:	Broker's Phone #:
Nature of Business: SIC Code: _____	UnitedHealthcare Account Executive's Name:

Employee's Name	Sex	Age or DOB	Please Circle One	Spouse's Age or DOB	# of Children
1.			EE, ESP, ECH, FAM, LO		
2.			EE, ESP, ECH, FAM, LO		
3.			EE, ESP, ECH, FAM, LO		
4.			EE, ESP, ECH, FAM, LO		
5.			EE, ESP, ECH, FAM, LO		
6.			EE, ESP, ECH, FAM, LO		
7.			EE, ESP, ECH, FAM, LO		
8.			EE, ESP, ECH, FAM, LO		
9.			EE, ESP, ECH, FAM, LO		
10.			EE, ESP, ECH, FAM, LO		
11.			EE, ESP, ECH, FAM, LO		
12.			EE, ESP, ECH, FAM, LO		
13.			EE, ESP, ECH, FAM, LO		
14.			EE, ESP, ECH, FAM, LO		
15.			EE, ESP, ECH, FAM, LO		
16.			EE, ESP, ECH, FAM, LO		
17.			EE, ESP, ECH, FAM, LO		
18.			EE, ESP, ECH, FAM, LO		
19.			EE, ESP, ECH, FAM, LO		
20.			EE, ESP, ECH, FAM, LO		

EE = Employee, ESP = Employee/Spouse, ECH = Employee/Children, FAM = Family, LO = Life Only

Please list any ongoing serious medical conditions, existing pregnancies and any condition requiring medical treatment in the amount of \$5,000 or more during the last five years. Use an additional sheet, if necessary.

Ancillary Benefits:

Life/AD&D Benefit Level: _____ Dependent Life: <input type="checkbox"/> \$2000 Spouse/\$1000 Child <input type="checkbox"/> \$4000 Spouse/\$2000 Child <input type="checkbox"/> \$7500 Spouse/\$3750 Child	Dental Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
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