UnitedHealthcare®

Plan "Opt Out" Form

Complete this form if you want to continue to receive coverage from UnitedHealthcare and opt out of the HealthConnections Prime Program. Please return this form by December 31, 2018.

Member information

Member Name_____

Address_____

City_____ ST_____ Zip Code_____

County _____

Member ID_____ Email address _____

Phone number _____ Alternate phone _____

Emergency contact information

Emergency contact name _____

Emergency contact phone number _____

Authorized representative information

If you are completing this form for the member, please provide the following information and sign and date below:

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number _____

Relationship to member _____

Signature _____ Date _____

Signature

I am providing written notice that I want to keep my coverage from UnitedHealthcare and opt out of the HealthyConnections Prime Program.

Signature _____ **Date** _____