Wyoming Small Business (Groups of 1–50)

Product and Benefit Selection Form

UnitedHealthcare Multi-Choice® Package (WY009)

General Information

Group Name

Agent Name

Billing Type

☐ Paper Billing ☐ Online Only/Ebill ☐ Electronic Funds Transfer

Deductible

☐ Calendar Year (from Jan. 1 to Dec. 31) ☐ Policy Year (from policy effective date to renewal date)

Please select which medical plan(s) will be offered to employees.

Network and Non-Network

Choice Plus Plans

Select	Plan Code	Description	Rx Plan
☐	COG2	10/250/90%	L23Y
☐	COG9	15/500/80%	L23Y
☐	COHL	20/500/50%	L22Y
☐	COHR	30/1000/75%	L24Y
☐	CD5S	1250/80%	L22Y
☐	COG4	30/1500/80%	L24Y
☐	COG3	25/2000/80%	L25Y
☐	COHI	2500/80%	L22Y
☐	COHA	30/3000/80%	L23Y
☐	COHM	40/2000/50%	L22Y
☐	COHO	2500/70%	L22Y
☐	COHN	35/3000/60%	L22Y
☐	COHK	50/3500/70%	L22Y
☐	COG6	35/5500/80%	L22Y
☐	COG7	5500/80%	L22Y
☐	COHP	60/5500/70%	L22Y
☐	COHH	6500/80%	L22Y
☐	COHJ	50/6500/70%	L26Y
☐	COHG	5500/50%	L26Y
☐	COHF	60/8500/60%	L22Y
☐	COHQ	8550/100%	L26Y

Network and Non-Network

Choice Plus HSA (Non-Embedded Plans)

Select	Plan Code	Description	Rx Plan
☐	COG5	1500/80%	L21Y
☐	COG8	2500/80%	L21Y

Choice Plus HSA (Embedded Plans)

Select	Plan Code	Description	Rx Plan
☐	COHC	2900/80%	L21Y
☐	COHB	3500/70%	L21Y
☐	COHD	6150/80%	L21Y
☐	COHE	6650/90%	L21Y

If an HSA plan is selected, which bank will be used?

☐ Optum Bank® ☐ Other

Dental Plan

☐ Plan Code ☐ Plan Code ☐ Not Elected

Vision Plan

☐ Plan Code_____ ☐ Not Elected

Basic Life Amount

Employee

☐ Flat Amount $ _____

☐ 1x Salary

☐ 2x Salary

Dependent

☐ Spouse $ _____

☐ Child(ren) $_____

Please indicate salary amount on enrollment form for each employee for multiple of salary life.

Group Name: _____

Supplemental Coverage

Life/AD&D $ _____ STD/LTD $_____(Indicate plan codes)

- Complete addendum to Employer Application for Supplemental Life and Disability Lines of Coverage.
- Life/AD&D applies to groups with more than 10 eligibles; maximum amount is $100,000.
- Supplemental Life must be sold with Basic Life.
- Please indicate salary amount on enrollment form for each employee for disability and multiple of salary life.

Other Notes

YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL-GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF 1-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.

The answers provided in this Product and Benefit Selection Form are accurate and complete to the best of my knowledge and belief, and the Insurer shall rely and act upon them accordingly.

This Product and Benefit Selection Form must accompany the Employer Application for Small Business.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature

Employer Signature	Title	Date