DRL
Doyle Rowe LTD

Thank you for your interest in the Alabama State Lodge FOP Endorsed Dental and Vision Plans.

Enclosed you will find enrollment forms, highlights of the plans, and payment information. Members have the option of enrolling in the dental plan only, the vision plan only or both the dental and vision plans.

Be sure to fill in the forms completely. If you have questions while you are completing the forms contact the Doyle Rowe LTD Enrollment Hotline at 1-866-201-2524.

Choose your payment option. Monthly premiums are as follows:

	Dental Only	Vision Only	Both
Single	**$41.36**	**$7.24**	**$48.60**
Single + One	**$80.48**	**$18.05**	**$98.53**
Family	**$131.66**	**$18.05**	**$149.71**

You may pay your premium via monthly bank draft or quarterly, semi-annual or annual check. If you choose to pay your premiums using a check, you must supply either Visa or Mastercard information as well. Your credit card will only be charged if your payment is not received by the 15th of the month in which it is due. If you choose to remit payment via quarterly, semi-annual or annual check please include your first payment. You will be billed 30 days before your next payment is due. **Please make checks payable to: Doyle Rowe LTD**. Be sure to write FOPUHC on the memo line. Bank drafts or credit card payments will appear as a payment made to Doyle Rowe LTD on your bank or credit card statement.

Applications received by the 20th of each month will become effective on the first of the next month, those received after the 20th will become effective on the first of the month following the next month, e.g. forms received on May 19 will become effective on June 1, those received on May 21 will become effective on July 1. **Remember a one year enrollment is required**.

You may visit www.myuhcvision.com to locate a provider, track claim status, trace an order or obtain answers to frequently asked questions.
Or
www.myuhcdental.com to find an in network dentist. Simply click the "dentist locator," select "PPO National Network" and enter your zip code. You may also track claim status, and access cost estimate tools using this site.

Please return your completed forms to:

Doyle Rowe LTD 1301 W. 22nd St. Suite 101 Oak Brook, IL 60523

Again, please direct your questions to Doyle Rowe LTD at 1-866-201-2524. United Healthcare Dental and Vision are privileged to offer benefits to the members of the Alabama State Lodge FOP. We look forward to providing you with quality, affordable dental and vision plans.

	NON-ORTHODONTICS NETWORK	NON-NETWORK		
Individual Annual Calendar Year Deductible	$50	$50		
Family Annual Calendar Year Deductible	$150	$150		
Maximum *(the sum of all Network and Non-Network benefits will not exceed annual maximum)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year		

New enrollee's waiting period:	
Annual deductible applies to preventive and diagnostic services	No (In Network) No (Out Network)

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Calendar Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services (incl. Emergency Treatment)	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)	50%	50%	Once per tooth per consecutive 60 months.

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months.Exception to this limit will be made for Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per CalendarYear

EXTRAORAL RADIOGRAPHS Limited to 2 films per CalendarYear

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.

FULL MOUTH DEBRIDMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

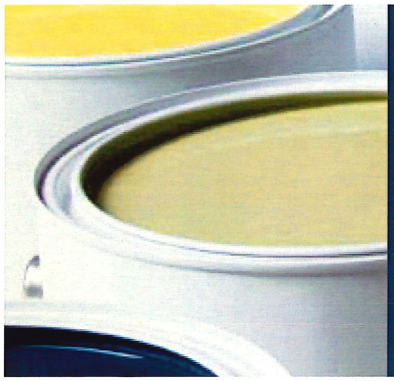
PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Foreign services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities.
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.



Dental

A Dental plan that's easy to chew

Taking good care of your teeth is an important part of maintaining your overall health. That's why UnitedHealthcare Dental wants to make keeping your mouth healthy as easy as possible.

If you enroll in the UnitedHealthcare Dental program, these are some of the benefits you will receive:

- Access to an extensive national network of dentists
- Ability to visit any specialist you want without a referral
- No paperwork*
- Preventive care, including exams and cleanings, at little or no out-of-pocket cost
- **Up to 30% savings** on services from network dentist
- Freedom to choose a non-network dentist
- Access to the only claims cost calculator on the market today that can determine exact out of pocket expenses based on your plan.
- Easy access to your benefit information at myuhcspecialtybenefits.com

** No claim forms for in-network services*

Enroll today to receive this important benefit. For more information about your dental insurance options, refer to your benefits summary.

With a UnitedHealthcare Dental plan you can save money and invest in a healthy smile to last a lifetime. Here's how:

Annual cost comparison

Covered participants	Dental services	Average cost without a dental plan	Cost with our dental plan	Savings with our dental plan
Employee	Semiannual exams, cleanings, and x-rays. One filling, One root canal	$1,195	$453	$742
Employee and Spouse	Semiannual exams, cleanings, and x-rays. Two fillings, One root canal	$1,580	$666	$914
Employee and Family (Spouse and two children)	Semiannual exams, cleanings, and x-rays. Two fluoride treatments, four fillings, One root canal	$2,344	$909	$1,435

Enroll today to receive this important benefit. For more information about your dental insurance options, refer to your benefits summary.

** Average cost without a dental plan are based upon national average 'Usual and Customary' rates published by Ingenix.*

*** Costs with the voluntary plan include: national average tax-adjusted (20% pre-tax discount) premiums which are 100% paid by employee, national average coinsurance amounts, and annual deductible. Coinsurance costs for the voluntary dental plan are based on network utilization of a 100/80/50 plan design with a $50/$150 annual deductible. Premiums will vary upon geographic region, total group enrollment in plan, and group demographic factors.*

For more information visit us at myuhcspecialtybenefits.com

UnitedHealthcare Specialty Benefits unites health and financial well-being for individuals and organizations, through integrated and personally relevant products, services and technologies. We offer a broad array of specialty insurance products. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates. All products may not be available in all states. UnitedHealthcare Specialty Benefits is a brand of UnitedHealth Group.

UnitedHealthcare Dental®

What works for you?℠

UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare Dental Enrollment Form

SOCIAL SECURITY NUMBER	NAME, LAST	FIRST	MI

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER

Home ( ) Work ( )

[ ] Male [ ] Female

[ ] Single [ ] Married

APPLICANT'S DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Single ☐ Single + Spouse ☐ Single + Child(ren) ☐ Family

☒ UnitedHealthcare Dental Options PPO Plan

☐ UnitedHealthcare Dental Managed Indemnity Plan

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name	Initial	Last Name (If different)	Date of Birth (Mo/Day/Yr)	Relationship	
				[ ] Husband	[ ] Wife
				[ ] Son	[ ] Daughter
				[ ] Son	[ ] Daughter
				[ ] Son	[ ] Daughter
				[ ] Son	[ ] Daughter

FOR INTERNAL USE ONLY

Employer Authorization

Effective date

Type of coverage

SIGNATURE _____

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

MINIMUM ENROLLMENT IS ONE YEAR

The UnitedHealthcare Dental Managed Indemnity Plan and the UnitedHealthcare Dental Options PPO Plan are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York) United HealthCare Insurance Company of New York, Hauppauge, New York (New York only)

100-2659 1/00

White: UHC copy Yellow: Applicant copy

UnitedHealthcare

Vision Services	UnitedHealthcare Insurance Company Primary Plan	
	In Network	Out of Network
Plan Options		
Contribution	Voluntary	
Product Type	Exam with Materials	
Network Type	Standard Network	
Exam(s) Co-pay	$10	Not Applicable
Material Co-pay (Frames/Spectacle Lenses or Contact Lenses)	$25	Not Applicable
Service Frequency		
Exams/Lenses/Frames/Contacts	12/12/24/12	
Eye Examination		
Exam(s) (Includes additional eye exam for ages 0-12 and pregnant or breastfeeding women)	100%	Up to $40
Lenses		
Single Vision	100%	Up to $40
Lined Bifocal	100%	Up to $60
Lined Trifocal	100%	Up to $80
Lenticular	100%	Up to $80
Frames		
Retail Frame Allowance	Up to $130	Up to $45
Discount on Frame Overage at participating providers	30%	Not Applicable
Elective Contact Lenses		
Covered Formulary Contacts	Up to 6 boxes	Up to $150
Non-Formulary Contacts	Up to $150	Up to $150
Necessary Contact Lenses	100%	Up to $210
Lens Options		
Covered-in-full Lens Options	Polycarbonate Lenses for Children up to Age: 19 Standard Scratch Coating	Not Applicable
Non-covered Lens Options	Price Protection available for non-covered lens options ranging from 20-60% off retail pricing at participating providers (except where not permitted by state law)	
Value Services		
Laser Vision Discount	UnitedHealthcare is proud to add value to your vision care program by offering access to discounted laser vision correction procedures through QualSight LASIK, the largest LASIK manager in the United States. Member savings represent up to 35% off the national price of LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. Visit myuhcvision.com for more information.	
Children's and Maternity Eye Care Replacement Eyeglasses		
Additional eyeglass frame/lenses due to prescription change (ages 0-12 and pregnant or breastfeeding women).	Members ages 0-12 and members pregnant or breastfeeding who have a prescription change of 0.5 diopter or more are eligible for a replacement frame and lenses. The replacement benefits are the same as the benefits for the initial frame and lenses. Not applicable for Exam Core or Exam with Discounted Material Plans.	
Rates		
Employee	$7.24	
Employee + Family	$18.05	

UnitedHealthcare®

Enrollment Form

Group Vision Care Insurance
Provided by UnitedHealthcare Insurance Company

Alabama Fraternal Order of Police

Check the Appropriate Boxes

Requested Effective Date of Coverage / Date of Change: / / ☐ Enroll ☐ Cancel ☐ Change

Reason: ☐ New Group Plan ☐ New Hire ☐ Annual Open Enrollment ☐ Address Change ☐ Name Change ☐ Employee Terminated ☐ Marriage ☐ Divorce ☐ Death ☐ Birth ☐ Adoption/Legal Custody ☐ Court ordered Dependent ☐ Dependent married/reached age limit ☐ Cobra/State Continuation ☐ Other:

Employee Information

Social Security Number: - - | Date of Birth: / /

Last Name: | First Name: | Middle Initial:

Address:

City: | State: | Zip Code:

Home Phone: | Work Phone: | Email Address:

Sex: ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Coverage Selection

Plan Coverage: ☐ Employee Only ☐ Employee + Spouse (or Domestic Partner*) ☐ Employee + Child(ren) ☐ Family

Family Information

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number	Date of Birth	Sex	Relationship**	Full-time Student
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

V-ENROLL-ER

Other Vision Coverage Information

On the day this coverage begins, will you, your spouse (or domestic partner*), or any of your dependents be covered under any other vision care insurance plan or policy including another UnitedHealthcare Insurance Company vision care insurance plan or Medicare?
☐ Yes ☐ No

Spouse (or Domestic Partner*) Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer.

Employee/Applicant Signature
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

The Certificate provides vision care insurance benefits only. Review your Certificate carefully.

FRAUD WARNING NOTICE{S}: {(Please review the notice that applies in your state.)}

{For applicants in {Arkansas} {and} {West Virginia} {and} {Rhode Island}:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.}

{For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.}

{For applicants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.}

{For applicants in Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.}

{For applicants in Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.}

{For applicants in New Mexico:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.}

{For applicants in Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.}

{For applicants in Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.}

{For applicants in Oregon:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.}

{For applicants in the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.}

{For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.}

{For applicants in Florida:
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.}

Employee/Applicant Signature:	Date: / /

To Be Completed by Employer

Employer Name:			Enrollee Effective Date: / /	Class Code:
Enrollment: ☐ New Hire ☐ Other	Date of Hire: / /	Policy Number:	Plan Variation/ Reporting Code:	Plan Code:
Employer Authorization:				

Group vision care insurance products are underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut.

UnitedHealthcare Insurance Company

UnitedHealthcare®

DRL
Doyle Rowe LTD

Premium Payment Option and Authorization

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City/State/Zip _____

Phone _____ Fax _____ Email Address _____

Financial Institution Debit Authorization - membership premium deducted from bank account:
Monthly Electronic Fund Transfer Type: Checking ☐ Savings ☐

Account Holder Name: _____

Bank Name: _____

Bank Account Number: _____

Bank Routing Number: _____

Account Owner Signature: _____
(if different than applicant)

I hereby authorize Doyle Rowe LTD to accept payment by monthly bank draft for the plan(s) I have chosen to enroll in using a separate enrollment form. This authority will remain in effect for a period of not less than one year from the effective date of coverage and thereafter until canceled by written notice to Doyle Rowe LTD from me.

Signature _____ Date _____