Senior Benefit Services Inc.
800-924-4727

Appointment Application

UnitedHealthcare Insurance Company and Affiliates

UnitedHealthcare Medicare Solutions

THIS IS A WRITABLE FORM*

Please Print or Type: All fields must be complete and legible

Individual Information (All Individual Information fields required for all Appointment Applications).			
Legal Name (As name appears on Individual Resident State in insurance License) Last: Middle: First:			
Social Security Number	Birth Date (MM/DD/YYYY)	Alias/Other Names	
Resident Address			
City	State	County (FL only)	Zip
Resident Phone Number	Business Phone Number	Fax Number	
Email Address			
Appointment Type: ☐ Individual OR ☐ Corporation	This must match information provided on the Agreement and W-9.		
Mailing Preference: ☐ Residential OR ☐ Business	If applying as an individual, but prefer mail be delivered to your business, fill in the Business Address section below.		

If Applying as a Corporation, the following information is also required. (You must be a Principal of the Corporation to Apply).			
Corporation Name		Principal	
Corporate Tax ID		Business Phone	
Business Address			
City	State	County	Zip

Errors and Omissions Coverage ($1,000,000 per occurrence or $1,000,000 annual aggregate required.)		
AN ACTIVE POLICY DECLARATION PAGE WITH YOUR NAME LISTED AS THE COVERED ENTITY MUST BE ATTACHED.		
Name of Carrier	Expiration Date	Policy #

Conditions and Agreements

I have thoroughly reviewed this application and have answered all questions to the best of my knowledge. By signing below, I hereby attest to all matters set forth above and agree to all matters set forth below.

I hereby agree that if and when any or all of the companies issue to me any Agreement(s) for which I hereby apply, I will be bound by such Agreement(s). I understand that my supervising office has specimen forms of the Agreement(s) on file and I have had the opportunity to review such Agreement(s). Submitting to the Company any application for insurance products, including but not limited to Medicare Advantage and Prescription Drug Plan, shall constitute my agreement to such Agreement(s) and all the terms, conditions and provisions set for therein..

I Acknowledge that by signing this Appointment Application and submitting any such insurance application for Insured Product, I have so agreed to the Agreement(s) and no future signature by me shall be necessary.

Disclosure

I have executed this Appointment Application as evidence of the understanding and acceptance of, and consent to its terms, and I agree that I will not solicit business until I receive notification from the Company that this acknowledgment has been approved and I have satisfied all of the certification requirements for the products I intend to sell.

I understand that as part of its approval process and throughout the term of my appointment with the Company, the Company may obtain an investigative consumer report to confirm information regarding my character, general reputation, credit history, personal characteristics, mode of living, criminal history, insurance licensing history, Office of Inspector General records and General Service Administrator excluded party records. I hereby authorize the Company to obtain such a report at any time after receipt of this Appointment Application and throughout the term of my appointment with the Company. The scope of this authorization is all-encompassing, allowing the Company to obtain from any outside organization all manner of investigative consumer reports now and throughout my appointment to the extent permitted by law.

Applicant's Signature	Date	SIGNATURE

Please return all documents to your Recruiter for submission to UnitedHealthcare.

RETURN COMPLETED CONTRACTING TO:

Senior Benefit Services, Inc
13511 Label Lane Suite 204
Hagerstown, MD 21740
Phone: 1-800-924-4727
Fax: 301-733-1776
Email: Licensing@srbenefit.com