Insured Employer Application

UnitedHealthcare Insurance Company
450 Columbus Avenue
Hartford, CT 06115

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

General Information

Requested Effective Date (mm/dd/yyyy) _____ / _____ / ______

Group's/Company's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	

Billing Address (if different)	# of Years in Business

Multi-location group/company? ☐ Yes ☐ No	# of Locations	Address(es) (or list on additional sheet of paper)

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other ____________________	Nature of Business	Industry Code

Waiting Period for new hires	Waiting Period waived for initial enrollees	Medical Benefit Plan Option	ERISA Plan?
☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following ___ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ ____ [months] [days] of employment following Date of Hire ☐ Other ____	☐ Yes ☐ No	☐ Calendar Year ☐ Policy Year	☐ Yes ☐ No

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (subscribers/dependents)	Number of Subscribers Termed in last 12 Months	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Name of Workers' Compensation Carrier	Names of Owners/Partners not covered by Workers' Compensation

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Subscribers Applying for:		# Subscribers Waiving for:		**Contribution**	Employer %	Employer % for Dep
# Eligible Subscribers		Medical		Medical		Medical		
# Ineligible Subscribers		Dental		Dental		Dental		
Total # Subscribers		Vision		Vision		Vision		
		Basic EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
		Basic Dep Life		Basic Dep Life		Basic Dep Life		
# Hours per week to be eligible* *		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
# of weeks of Travel		Business Travel Medical		Business Travel Medical		Business Travel Medical		
# of Travelers		Travel AD&D		Travel AD&D		Travel AD&D		
* *For Disability products the minimum # of work hours per week to be eligible is 30 hours.		LTD		LTD		LTD		
		Other		Other		Other		

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

☐ Yes ☐ No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

☐ Yes ☐ No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be place voluntarily into bankruptcy?

☐ Yes ☐ No Is your group a Professional Employer Organization (PEO) or Subscriber Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site subscriber(s)?

If you answered Yes, then by signing this application you agree with the certification in this section.

I hereby certify that my company is a PEO, ELC or other such entity and that only those subscribers that are the corporate subscribers of my company, and not my co-subscribers, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-subscribers under the group's plan, I understand that UnitedHealthcare will not cover the co-subscribers under this group policy.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an subscriber begins a leave of absence? ☐ Yes ☐ No

(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an subscriber is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)

☐ 3 Months (following the last day worked for the minimum hours required to be eligible)

☐ 6 Months (following the last day worked for the minimum hours required to be eligible)

☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for:
(1) No longer than 3 consecutive months if the subscriber is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the subscriber is totally disabled.

If this coverage terminates, the subscriber may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number ______________________ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Business Travel Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Long-Term Disability Carrier	☐ None			

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of subscribers or their dependents, including the addition of any newly eligible subscribers or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible subscriber or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of subscribers and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any subscribers and dependents who have elected continuation of insurance benefits. I understand that material omissions, misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's subscribers.

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, and may subject the individual to criminal and civil penalties.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of subscribers. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature ________________________________ **Date (mm/dd/yyyy)** ___ / ___ / ____ **Title**_________________________

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

I hereby certify that I have truly and accurately recorded information supplied by the insured on this form

Signature ____

Broker Name	Agency	Agent Code/Tax ID Number	
Email Address	Social Security #	Phone Number	Date

Broker Commission ___________ %

For internal use only

Rep Name	Rep #