(DO NOT STAPLE)

Employer Application for Small Business

Groups with 2-99 Eligible Employees

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address	Tax ID

City	State	Zip Code	Names of Owners/Partners (if applicable)

Contact Person	Telephone	Fax	Email Address

Billing Address (If Different)	# of Years in Business

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other________	Nature of Business	Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No	# Locations	Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.	Subject to ERISA regulation ☐ Yes ☐ No

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

Have Workers' Comp ☐ Yes ☐ No	Workers' Comp Carrier Name	Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability: ☐ See Attached List ☐ None	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Participation

		# Employees Applying for:		# Employees Waiving for:	
# Eligible Employees		Medical		Medical	
# Ineligible Employees		Dental		Dental	
Total # Employees		Vision		Vision	
		Basic Life/AD&D		Basic Life/AD&D	
		Dep Life		Dep Life	
# Hours per week to be eligible** ________		Supp Life/AD&D		Supp Life/AD&D	
		Dep Supp Life/AD&D		Dep Supp Life/AD&D	
		STD		STD	
		STD Buy Up		STD Buy Up	
		LTD		LTD	
		LTD Buy Up		LTD Buy Up	
		Other		Other	

**For Disability products the minimum # of work hours per week to be eligible is 30 hours.

Contribution

Contribution	Employer %	Employer % for Dep
Medical		
Dental		
Vision		
Basic Life/AD&D		
Dep Life		
Supp Life/AD&D		
Dep Supp Life/AD&D		
STD		
STD Buy Up		
LTD		
LTD Buy Up		
Other		

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Arizona, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Arizona, Inc. or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy (including, but not limited to termination following a leave of absence)? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee 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*
☐ Other (please provide a copy for our records)

***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 employee 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 employee is totally disabled.

If this coverage terminates, the employee 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 Dental Carrier	☐ None			
Current Vision Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

Questions Regarding Group Size

☐ COBRA	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation.
☐ Medicare Primary ☐ Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.
☐ Yes ☐ No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each.
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(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 employees that are the corporate employees of my company, and not my co-employees, 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-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

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.

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 size and number of employees. 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 pursuant to 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 enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date

Commission Information

Writing Broker Name	Writing Broker SSN		Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split ______%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	**Broker Signature**	**Date**

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address

UnitedHealthcare®
A UnitedHealth Group Company

Scheduled Direct Debit Authorization Form

Enrollment Instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.

STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Debit, I agree to and/or understand all of the following on behalf of my group:

It may take up to one month to establish this process. If a customer is overdue on a prior bill, a delinquency letter will be sent to the customer, and must be paid to ensure the account is not cancelled prior to the process being set up.

I authorize UnitedHealthcare to debit my group's checking or savings account for all monthly charges for coverage.

I ensure sufficient funds are in my group's checking or savings account to cover my premium invoice.

If the necessary funds are not on deposit in the account at the beginning of the month, my group's coverage may be subject to termination under the terms stated in the contract with UnitedHealthcare. Also, my group may be subject to additional fees incurred by UnitedHealthcare subsequent to the termination date as a result of insufficient funds.

I will promptly notify UnitedHealthcare of any change to my group's checking or savings account. If a change occurs it is my responsibility to provide UnitedHealthcare with the current information.

AUTHORIZATION

I hereby authorize UnitedHealthcare to initiate debits (payments) to the financial institution indicated below for the purpose of paying my group's monthly bill. This financial institution is authorized to debit my account. This authority is to remain in full force and effect until either my group revokes it by giving 30 days prior written notice to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above, or upon termination of my group's coverage with UnitedHealthcare. I have also read and, on behalf of my group, agree to the terms and conditions outlined above.

Authorized Signature | Date

Employer Name/Customer Name/Policy Name | Employer Email Address

Customer Number and Bill Group(s)

Name of Your Financial Institution and Location State

Phone Number of Financial Institution

Transit / American Bankers Association #
Number can be found in lower left corner of your check

Account Number to Debit
Debits to your account will be made on the beginning of each month

UnitedHealthcare – Duluth
MN015-2838 Billing
4316 Rice Lake Road
Duluth, MN 55811

C/P

Employer eServices

Becoming a UnitedHealthcare customer has its privileges!

As a UnitedHealthcare customer, the group contact listed on the Employer Group Application will automatically be enrolled in Employer eServices and emailed a User ID and Password. The Employer eServices Web site provides easy access to benefit administration, with 24 hour convenience to make benefit management simpler, easier and better!

With Employer eServices, you have real-time administration to:

Verify eligibility
Review enrollment information
Add employees and dependents
Change eligibility
Reinstate employees
Terminate employees
Request employee ID cards
Select or Change Primary Care Physician (as required by plan)
Delegate benefits administration work to additional staff

Once you receive your User ID and Password, simply go to www.employereservices.com.

We believe in putting the power of information into the hands of our customers!