



Group Name \_\_\_\_\_

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
# Hours per week to be eligible _____		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 for Disability coverage if different from above ** _____		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		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD		STD		STD		
		STD Buy Up***		STD Buy Up***		STD Buy Up***		
***Only available to Groups with 100+ Eligible Employees		LTD		LTD		LTD		
		LTD Buy Up***		LTD Buy Up***		LTD Buy Up***		
		Voluntary AD&D***		Voluntary AD&D***		Voluntary AD&D***		
		Other		Other		Other		

**General Information (continued)**

Enter the Prior Calendar Year Average Total Number of Employees  Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees  For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year.

In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

Yes  No Subject to ERISA? (Most private sector plans are ERISA plans)  
 If No, please indicate appropriate category:  
 Church (Additional information needed)  Federal Government  
 Indian Tribe – Commercial Business  Non-Federal Government (State, Local or Tribal Gov.)  
 Foreign Government/Foreign Embassy  Non-ERISA Other \_\_\_\_\_

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 placed voluntarily into bankruptcy?

Yes  No Does your group sponsor a plan that covers employees of more than one employer?  
 If you answered Yes, then indicate which of the following most closely describes your plan:  
 Professional Employer Organization (PEO)  Multiple Employer Welfare Arrangement (MEWA)  
 Taft Hartley Union  Governmental  
 Church  Employer Association

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) or 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.

Yes  No Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?

Yes  No Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Group Name \_\_\_\_\_

**General Information (continued)**

**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 employee begins 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\*
- No, we do not offer medical coverage during a leave of absence

**\*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.

**HRA and Supplemental Insurance Information**

**Health Savings Account** (if selected): Which bank will be used:  OptumBank  Other

**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 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 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.

**HRA/HSA Employer Premium Contribution**

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

**HRA/HSA Employer Account Funding Amount**

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed?  Yes  No

Who will provide account balances to UnitedHealthcare?

**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	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	<input type="checkbox"/> None			
Current Dental Carrier	<input type="checkbox"/> None			
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			
Current Vision Carrier	<input type="checkbox"/> None			



Group Name \_\_\_\_\_

**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 employees or their dependents, including the addition of any newly eligible employees 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 employee 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 employees and their dependents in providing coverage under the policy/policies for which application is being made. If the Group prefers hard copies of these documents and communications, I understand that I may contact the Company to make this request.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, 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 employees.

ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED THE STATE LAW.

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:

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, if applicable, are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established 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. 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 may be 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. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

**Signature** (Form must be signed)

Group/Company Signature \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_

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

**Producer Information (if applicable)**

Producer Name	Agency	Agent Code/Tax ID Number	
Email Address	Social Security #	Phone Number	
All Payments to:	Producer Commission Schedule (if applicable) _____ Std Scale of _____%		
Street Address	City	State	Zip Code

Yes  No To the best of my knowledge, acceptance of this application will replace existing life insurance coverage.

Producer Signature	Date
Rep Name	Rep #

**General Agent Information (if applicable)**

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