

# Employer Application for Large Group

Tennessee



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.

- UnitedHealthcare Insurance Company
- UnitedHealthcare Insurance Company of the River Valley
- UnitedHealthcare Plan of the River Valley, Inc.

## General Information

Requested Effective Date \_\_\_\_\_

Group's/Company'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)	Internet Access? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Person	Email Address		# of Years in Business	
Billing Address (if different)			Telephone	Fax
Multi-location group/company?*	# of Locations	Address (es) (or list on additional sheet of paper)		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Organization Type	Nature of Business		Industry Code	
<input type="checkbox"/> Partnership <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other _____				
Waiting Period for new hires			Waiting Period waived for initial enrollees	Medical Benefit Plan Option
(Waiting period for medical coverage cannot exceed 90 days)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Calendar Year <input type="checkbox"/> Policy Year
<input type="checkbox"/> 1st of Policy Month following Date of Hire <input type="checkbox"/> 1st of Policy Month following ___ <input type="checkbox"/> months <input type="checkbox"/> days of employment <input type="checkbox"/> Date of Hire (no waiting period) <input type="checkbox"/> ___ <input type="checkbox"/> months <input type="checkbox"/> days of employment following Date of Hire				
Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)	Number of Employees Termed in last 12 Months	Classes Excluded: <input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Management <input type="checkbox"/> Salary		
Have Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Workers' Compensation Carrier			
Names of Owners/Partners not covered by Workers' Compensation				

\*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

Participation	# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
	Medical	Dental	Medical	Dental			
# Eligible Employees					Medical		
# Ineligible Employees					Dental		
Total # Employees					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		

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

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

### 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.

### UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, 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.

### Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

\_\_\_ Yes, we continue medical coverage during an approved leave of absence for full time\* employees (as defined on page 1).

\_\_\_ No, we do not offer medical coverage during a leave of absence.

### 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.

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

**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			

**Disclosures**

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

**IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.**

- Yes  No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?
- Yes  No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?
- Yes  No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?
- Yes  No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?
- Yes  No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?
- Yes  No 6. Is any employee or dependent currently hospitalized?
- Yes  No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?
  - Cancer (any type)
  - Lung disease or respiratory problem (any type)
  - Heart disease or disorder (any type)
  - Organ, tissue or cell transplant
  - Liver disease (any type)
  - Kidney disease (any type)
  - Pancreatic disorder (any type)
  - Diabetes
  - Hepatitis
  - Morbid obesity
  - Congenital abnormality
  - Vascular disease (any type)
  - Neurological disorder (any type)
  - Immunological disorder (reportable types)
  - Alcohol or drug addiction or abuse
  - Hemophilia or Blood disorder (any type)

If you have answered "Yes" to any of the questions above, please provide the requested information on the next page for each individual. If necessary, use additional sheets of paper.

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

**Disclosures (continued)**

Question Number	Check One Employee	Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	\$ Amount of Claims	Current Treatment

**Important Information**

The Group/Company certifies that the information provided above is complete and accurate. 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.

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. This consent remains in effect until it is withdrawn. The Group may withdraw their consent at any time or request a document in a paper or non-electronic form.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information, or conceals information for the purpose of misleading, in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

**Signature** (Form must be signed)

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

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

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

**Producer Information (if applicable)**

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

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