

Joint Health and Life Employer Application

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
- 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 the first month's premium
- 6 **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL**

Requested Eff Date

General Information

Group Name

Address		Tax ID	
City		State	Zip Code
Contact Person	Telephone	Email Address	
Billing Address (If Different)			Industry Code
Organization Type	<input type="checkbox"/> Partnership <input type="checkbox"/> Corp <input type="checkbox"/> LLC/LLP	Nature of Business	
<input type="checkbox"/> Ind. Contractor <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other _____			
Multi-Location Group	# Locations	Address(es) (or, list on additional sheet of paper)	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
List Names Currently on COBRA/Continuation		Waiting Period for new hires <input type="checkbox"/> Date of Event	
<input type="checkbox"/> See Attached List <input type="checkbox"/> None		<input type="checkbox"/> 1st of policy month following _____ months of employment	
Have Worker's Comp	List Owners/Partners not covered by Workers' Comp		
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Waiting period waived at initial enrollment	# Hours per week to be eligible	Classes Excluded	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Other _____	

Participation	# Applying for:	# Waiving for:	Name of Current Carrier	Contribution			Employer % for Dep
				Product	Employer %	Employee%	
# Full Time Employees	Health	Health		Product			
# Part Time Employees	Life	Life		Health			
# Ineligible Employees	Dental	Dental		Life			
Total # Employees	Vision	Vision		Dental			
	Other	Other		Vision			
				Other			

Please answer the following question:

Will you self-fund any portion of your employees' cost-sharing by offering a wrap-around plan, such as a Health Reimbursement Account (HRA), in addition to your UnitedHealthcare Small Group Plan? Yes No

If "No" and group does not disclose that they have a wrap-around or add one after the initial group enrollment, the group may be subject to re-rate.

Health Coverage Provided by United HealthCare Insurance Company
Life Coverage Provided by United HealthCare Insurance Company

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE COMPANIES AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> St Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a member of a "controlled group of corporations" as that term is defined by United States Internal Revenue Code section 414(b). If yes, please give the legal names of all other corporations within the controlled group and the number of employees employed by each.

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 Company'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 or state continuation laws – is accurate and truthful. I understand that the Insurer 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, or other consequences as permitted by law.

YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-99] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.

NOTE: 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. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. 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. 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

Employer Signature	Title	Date
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Commission Information

Writing Broker Name	Agency/Writing Broker SSN	Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commissions Payable to:	Payee Code/Tax ID#	If more than 1 Broker % Production _____%	
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 Employer submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	Broker Signature	Date
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For the Second Broker / Agent (if Applicable)

Writing Broker Name		Agency/Writing Broker SSN		Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commissions Payable to:			Payee Code/Tax ID#		If more than 1 Broker % Production _____%
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 Employer submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.			Broker Signature	Date
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General Agent Override Information

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

Admin Kit

Send Admin Kit To:	Address
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