Small Group Employer Application

UnitedHealthcare
A UnitedHealth Group Company

- ☐ UnitedHealthcare Choice Plus
- ☐ UnitedHealthcare Select Plus
- ☐ UnitedHealthcare Options PPO
- ☐ UnitedHealthcare Options PPO 80/80
- ☐ UnitedHealthcare Managed Indemnity
- ☐ [UnitedHealthcare Rhapsody]
- ☐ [UnitedHealthcare Overture ☐ Yes ☐ No
  Overture Package ____________(A-S)]

UnitedHealthcare Dental Benefits

Dental Managed Indemnity	☐ Yes	☐ No
Dental Options PPO	☐ Yes	☐ No
[Vision Benefits	☐ Yes	☐ No]
[Quality	☐ Yes	☐ No]
[Elite	☐ Yes	☐ No]
Life/AD&D Benefits	☐ Yes	☐ No
Dependent Life	☐ Yes	☐ No
Supplemental Life	☐ Yes	☐ No
Supplemental AD&D	☐ Yes	☐ No

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. Complete the Coverage and Benefit Options page(s) and attach to the application (if applicable).
4. Submit the most recent billing statement listing those currently insured and current status.
5. Submit most recent wage and tax statement.
6. Include a deposit check for the first month's premium.

General Information

Requested Effective Date ______________

Group Name

Address | Tax ID

City | State | Zip Code | County

Contact Person | Title | Telephone ( ) | Fax ( )

Billing Address (if different) | Email Address

Multi-location group? ☐ Yes ☐ No | # of Locations | Address (please list locations on additional sheet)

Years in Business | Nature of Business | Industry Code

Type of Organization ☐ C-Corporation ☐ S-Corporation ☐ Limited Liability Company ☐ Independent Contractor ☐ Nonprofit Organization ☐ Other ____________ | List names of eligible employees/dependents currently on COBRA/Continuation________________ ☐ See attached list

Total # Employees | # Full Time Employees | # Part Time Employees | # Applying (Please include those employees in their waiting period) | # Waiving | # Hours per week to be Considered Eligible

Termed in 12 months | Effective Date for New Hires: First of the month following the completion of _____ day waiting period. | Waiting Period Waived at Initial/Open Enrollment ☐ Yes ☐ No | # of Employees outside service area

Name of Current Medical Carrier ☐ None | # Yrs Covered | Name of Current Dental Carrier | # Yrs Covered

Employer Contribution – Medical Single ___% Family ___% | Employer Contribution – Dental Single ___% Family ___% | Employer Contribution – Life Single ___% Dependents ___% | Classes Excluded ☐ Union/Non Union ☐ None ☐ Other ______________

Worker's Comp Carrier | List Owners/Partners not covered by WC | Amount of deposit check

☐ Yes ☐ No	In the past 36 months, has the 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 Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ COBRA Continuation ☐ State Continuation	Under federal law if your group had 20 or more employees 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 less than 20 employees, you must provide State Continuation.
☐ Medicare Primary ☐ Health Plan Primary	Under federal law if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary.
☐ Yes ☐ No	Are you a member of a "controlled group of corporations" as that term is defined by United States Code section 414(b) (Internal Revenue Code)? If yes, please give the legal names of all other corporations within the control group and the number of employees employed by each.

Broker Information

Broker Name	Agency	Agent Code/Tax ID Number	

Signature	Email Address	Social Security #	Date

Rep Name	Rep #

The Company certifies to the best of their knowledge and belief that the information provided above is complete and accurate. Company shall notify the Insurer 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, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer 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 this Policy.

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

I represent to the best of my knowledge and belief the information I have furnished is accurate, and includes any employees and dependent 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 voiding or reformation of insurance.

Signature (Form must be signed)

Signature ____________________________ **Date** ______________ **Title** ____________________________

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