

# 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

Nature of Business

Industry (SIC) Code

Ind. Contractor  Sole Proprietor  Other \_\_\_\_\_

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] [days] of employment
- Date of Hire (no waiting period)
- \_\_\_\_ [months] [days] 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, and/or Short/Long Term Disability:

See Attached List  None

Classes Excluded:  None  Union  Hourly

Non-Management  Non-Owners

By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA administrator.

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			
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D			
		Dep Life		Dep Life		Dep Life			
# Hours per week to be eligible**		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D			
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D			
		STD		STD		STD			
		STD Buy Up		STD Buy Up		STD Buy Up			
		LTD		LTD		LTD			
		LTD Buy Up		LTD Buy Up		LTD Buy Up			
		Other		Other		Other			

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by UnitedHealthcare Insurance Company

Dental coverage provided by UnitedHealthcare Insurance Company 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 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\*

**\*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	<input type="checkbox"/> None			
Current Dental Carrier	<input type="checkbox"/> None			
Current Vision Carrier	<input type="checkbox"/> None			
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			

**Questions Regarding Group Size**

<input type="checkbox"/> 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 during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year.
<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. 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.
<input type="checkbox"/> Federally Compliant MH/SUD Benefits <input type="checkbox"/> Not Required	Under federal law, if your group averaged 51 or more total employees (remember to include part-time and seasonal employees) during the preceding calendar year, you must provide employees with benefits compliant with federal mental health and substance use disorder parity laws and regulations (MH/SUD Parity Compliant Benefits), if your plan provides MH/SUD benefits. If your group had 50 or fewer employees, you are not required to provide MH/SUD Parity Compliant Benefits.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

## Questions Regarding Group Size (continued)

- 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. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

## 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 material misrepresentation or fraudulent misstatement 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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
--------------------	---------

[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] 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.]

## Employer eServices Scheduled Direct Debit

**Sign up for UnitedHealthcare's Scheduled Direct Debit and have your premium payments automatically deducted from your bank account.**

If you're looking for new and better ways to help organize, streamline and generally make your job easier, there's no better place to start than with UnitedHealthcare's Scheduled Direct Debit.

That's because Scheduled Direct Debit is a safe, convenient and automatic way to pay your monthly insurance premiums.

All you do is sign up, then every month we automatically deduct your premium from your company's bank account.

Even better, Scheduled Direct Debit helps you better organize your payment records, streamlines your monthly invoice payment process and frees you up to get on with the business of your business.

**Enroll today in UnitedHealthcare's Scheduled Direct Debit program. Just fill in the simple form on the reverse side and return it to us. Do it today. And give yourself one less thing to worry about.**

### **Scheduled Direct Debit:**

- ▶ Lets you pay your premium at the same time each month.
- ▶ Provides predictable cash outflow.
- ▶ Gives you a consistent process for your premium payment.
- ▶ Provides an accurate record of your payment listed right on your bank statement.
- ▶ Means you'll never have to worry about missing an invoice or a deadline again. Everything's taken care of. Automatically.

*Get organized.*

*Get streamlined.*

*Get UnitedHealthcare's  
Scheduled Direct Debit.*

# 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.
3. Fax this form to the fax number on the bottom of the authorization form.

**IMPORTANT: Please return the completed form along with a voided check (no deposit slips please.)**

## Statement of understanding

By executing this document in the space provided below, I hereby confirm that I am authorized to act on behalf of the employer/customer ("Group") described below and agree on behalf of Group to the following terms and conditions:

- Group authorizes UnitedHealthcare to debit the group checking (account # provided below) for all monthly charges for coverage.
- Group understands that it may take up to one month to set up Scheduled Direct Debit and consequently all overdue premiums should be promptly paid in order to avoid receiving a delinquency letter and possible termination of your account during this initial set up period.
- Group understands and agrees that it will have sufficient funds in its account to cover the full premium invoice on the draft due date. If necessary funds are not in your account on the draft due date, group coverage may be subject to termination proceedings consistent with the terms stated in your UnitedHealthcare contract.
- Group agrees to promptly notify Unitedhealthcare of any change to the information provided.

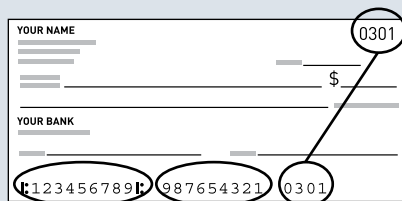
## Authorization

Authorization is given to UnitedHealthcare to initiate debits (payments) to the financial institution indicated below. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above; or upon termination of coverage with UnitedHealthcare.

## Determining your routing number

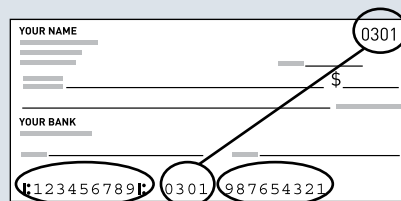
To determine your routing number, refer to your company check. **The routing number is always 9 digits long** and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank. For example:

Bank 1



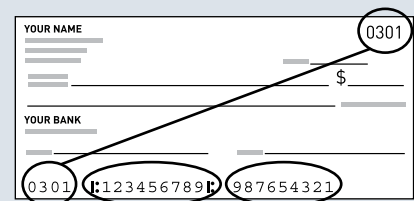
Routing # Account # Check #

Bank 2



Routing # Check # Account #

Bank 3



Check # Routing # Account #

If you are unsure what the routing number/transit number is, your bank can assist you.

**I have read and agree to the terms and conditions outlined above.**

Authorized signature and title of signatory

Date

Employer name/Customer name/Policy name

Employer email address

UnitedHealthcare customer number and bill group(s)

Name of your financial institution

Telephone number of financial institution

Routing/Transit Number (9 Digits)

Account Number (include all zeroes and omit spaces/special characters)

**Mail to:** UnitedHealthcare – Duluth  
Attn: Accounts Receivable  
MN 015-2838  
4316 Rice Lake Rd.  
Duluth, MN 55811

**OR**

**Fax to: 1-218-279-6493**  
Attn: Accounts Receivable

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

# 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](http://www.employereservices.com).

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