

# 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.**

- UnitedHealthcare of Tennessee
- UnitedHealthcare Plan of the River Valley
- UnitedHealthcare Insurance Company
- Unimerica Insurance Company

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

Nature of Business

Industry (SIC) Code

Multi-Location Group\* # Locations Address(es) (or list on additional sheet of paper)  
 Yes  No

\*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/Continuation, and/or Short/Long Term Disability:  
 See Attached List  None

Classes Excluded:  None  Union  Hourly  
 Non-Management  Non-Owners

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, UnitedHealthcare of Tennessee, Inc. or UnitedHealthcare Plan of the River Valley, Inc.  
 Dental coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Tennessee, Inc. or UnitedHealthcare Plan of the River Valley, Inc. 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 (including, but not limited to termination 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\*
- Other (please provide a copy for our records)

**\*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 <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 group'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. 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"/> Yes <input type="checkbox"/> 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.
<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.

## 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 or state continuation laws – 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 misrepresentation or fraudulent statement 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. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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
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## 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
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\*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
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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.