(DO NOT STAPLE)

Employer Application for Small Business

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.

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Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Address | Tax ID

City | State | Zip Code | County | 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 ☐ Non-Profit ☐ Sole Proprietor ☐ Other_____ | Nature of Business | Industry Code

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

Hours per week to be eligible | 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

Have Worker's Comp ☐ Yes ☐ No | Worker's Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation: ☐ See Attached List ☐ None | Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Has the Group been insured by UnitedHealthcare in the last 12 months: ☐ Yes ☐ No If yes, date coverage terminated: / /

Name of Current Medical Carrier ☐ None | Begin Date ___/___/___ End Date ___/___/___ | Name of Current Dental Carrier ☐ None | Begin Date ___/___/___ End Date ___/___/___

Participation		# Applying for:		# Waiving for:		Contribution	Employer %	Employee%	Employer % for Dep
# Full Time Employees		Medical		Medical		Medical			
# Part Time Employees		Life		Life		Life			
# Ineligible Employees		Dental		Dental		Dental			
Total # Employees		Vision		Vision		Vision			
		Other		Other		Other			

Questions Regarding Group Size

☐ COBRA ☐ 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.
☐ Medicare Primary ☐ 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. Check one.
☐ 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.

Coverage provided by "UnitedHealthcare and Affiliates":
Medical/Dental coverage provided by United HealthCare Insurance Company
Life Insurance coverage provided by United HealthCare Insurance Company
Vision coverage provided by United HealthCare Insurance Company

Please Continue On The Back Side Of This Form

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.

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. 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

Group Signature	Title	Date

Commission Information

Writing Broker Name	Writing Broker SSN			Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	Payee Code	CRID Code	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**

For the Second Broker / Agent (if Applicable)

Writing Broker Name	Writing Broker SSN			Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	Payee Code	CRID Code	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**

General Agent Override Information

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

Admin Kit

Send Admin Kit To:	Address

I authorize any required premium contributions to be deducted from earnings.

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

CONFIDENTIALITY

Make sure your employer has completed the "To be completed by the employer" section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.

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450-4413 11/04

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Your Rights and Responsibilities

Important Information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at **www.myuhc.com.**

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.
5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Pre-Existing Conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.

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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.

STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Debit, I agree to and/or understand all of the following on behalf of my group:

It may take up to one month to establish this process. If a customer is overdue on a prior bill, a delinquency letter will be sent to the customer, and must be paid to ensure the account is not cancelled prior to the process being set up.

I authorize UnitedHealthcare to debit my group's checking or savings account for all monthly charges for coverage.

I ensure sufficient funds are in my group's checking or savings account to cover my premium invoice.

If the necessary funds are not on deposit in the account at the beginning of the month, my group's coverage may be subject to termination under the terms stated in the contract with UnitedHealthcare. Also, my group may be subject to additional fees incurred by UnitedHealthcare subsequent to the termination date as a result of insufficient funds.

I will promptly notify UnitedHealthcare of any change to my group's checking or savings account. If a change occurs it is my responsibility to provide UnitedHealthcare with the current information.

AUTHORIZATION

I hereby authorize UnitedHealthcare to initiate debits (payments) to the financial institution indicated below for the purpose of paying my group's monthly bill. This financial institution is authorized to debit my account. This authority is to remain in full force and effect until either my group revokes it by giving 30 days prior written notice to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above, or upon termination of my group's coverage with UnitedHealthcare. I have also read and, on behalf of my group, agree to the terms and conditions outlined above.

Authorized Signature _____ Date _____

Employer Name/Customer Name/Policy Name _____ Employer Email Address _____

Customer Number and Bill Group(s) _____

Name of Your Financial Institution and Location State _____

Phone Number of Financial Institution _____

Transit / American Bankers Association # _____ Account Number to Debit _____

Number can be found in lower left corner of your check

Debits to your account will be made on the beginning of each month

UnitedHealthcare – Duluth
MN015-2838 Billing
4316 Rice Lake Road
Duluth, MN 55811

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.

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