

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.**

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 | Names of Owners/Partners (if applicable) |
|------|-------|----------|--|

| | | | |
|----------------|-----------|-----|---------------|
| Contact Person | Telephone | Fax | Email Address |
|----------------|-----------|-----|---------------|

| | |
|--------------------------------|------------------------|
| Billing Address (If Different) | # of Years in Business |
|--------------------------------|------------------------|

| | | |
|-------------------|--------------------|---------------------|
| Organization Type | Nature of Business | Industry (SIC) Code |
|-------------------|--------------------|---------------------|

| | | |
|----------------------|-------------|--|
| Multi-Location Group | # Locations | Address(es) (or list on additional sheet of paper) |
|----------------------|-------------|--|

| | | |
|---------------------------------|------------------------------|---|
| # Hours per week to be eligible | Waiting Period for new hires | Waiting Period waived for initial enrollees |
|---------------------------------|------------------------------|---|

| | | |
|--------------------|----------------------------|--|
| Have Worker's Comp | Worker's Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp: |
|--------------------|----------------------------|--|

| | |
|---|-------------------|
| Names of Persons currently on COBRA/Continuation: | Classes Excluded: |
|---|-------------------|

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

| | | | |
|---------------------------------|------------|--------------------------------|------------|
| Name of Current Medical Carrier | Begin Date | Name of Current Dental Carrier | Begin Date |
|---------------------------------|------------|--------------------------------|------------|

Do you currently offer or intend to offer a Health Reimbursement Account plan and/or voluntary or involuntary supplemental insurance (e.g., critical illness, hospital income, deductible reimbursement, etc.) policy along side this UnitedHealthcare/PacifiCare medical plan? Answers must be accurate whether purchased from UnitedHealthcare PacifiCare, or any other insurer or third party administrator.

HRA Yes No If yes, please identify type: Definity Standard HRA Definity Select HRA Other Administrator HRA
Supplemental Insurance Yes No
If you answered "Yes" for HRA, you must choose from the list of Definity HRA-eligible benefit plans as shown to you by your broker or agent. Other plans are not eligible for pairing with a Health Reimbursement Account.

| 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 | | | |

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by United HealthCare Insurance Company or PacifiCare Life and Health Insurance Company
 Dental coverage provided by United HealthCare Insurance Company
 Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
 Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

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 of the preceding calendar year, you must provide employees with COBRA 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 their 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. |

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 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/PacifiCare 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 Authorized Signature | Title | Date |
|----------------------------|-------|------|

Commission Information

| | | | |
|-------------------------|----------------------|--|----------|
| Writing Broker Name | Writing Broker SSN | Is the Broker appointed with UHC/PHS? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Commissions Payable to: | Payee Code | CRID Code | Tax ID# |
| 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/PHS 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 |
|--------------------|---------|

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 #

Number can be found in lower left corner of your check

Account Number to Debit

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

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!