(DO NOT STAPLE)

UnitedHealthcare
A UnitedHealth Group Company

Joint Health and Life Employer Application

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 Eff Date

General Information

Group Name

Address | Tax ID

City | State | Zip Code

Contact Person | Telephone | Email Address

Billing Address (If Different) | Industry Code

Organization Type ☐ Partnership ☐ Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Non-Profit ☐ Other____________ | Nature of Business

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

List Names Currently on COBRA/Continuation ☐ See Attached List ☐ None | Waiting Period for new hires ☐ Date of Event ☐ 1st of policy month following _________months of employment

Have Worker's Comp ☐ Yes ☐ No | List Owners/Partners not covered by Workers' Comp

Waiting period waived at initial enrollment ☐ Yes ☐ No | # Hours per week to be eligible | Classes Excluded ☐ None ☐ Union ☐ Other________________________________

Participation

Participation		# Applying for:		# Waiving for:		Name of Current Carrier
# Full Time Employees		Health		Health		
# Part Time Employees		Life		Life		
# Ineligible Employees		Dental		Dental		
Total # Employees		Vision		Vision		
		Other		Other		

Contribution

Product	Employer %	Employee%	Employer % for Dep
Health			
Life			
Dental			
Vision			
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 employer'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.
☐ Yes ☐ No	Are you a member of a "controlled group of corporations" as that term is defined by United States Internal Revenue Code section 414(b). If yes, please give the legal names of all other corporations within the controlled group and the number of employees employed by each.

Health Coverage Provided by United HealthCare Insurance Company
Life 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 Company'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 the Insurer 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, or other consequences as permitted by law.

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 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.

Signature

Employer Signature	Title	Date

Commission Information

Writing Broker Name	Agency/Writing Broker SSN	Is the Broker appointed with UHC? ☐ Yes ☐ No

Commissions Payable to:	Payee Code/Tax ID#	If more than 1 Broker % Production ______%

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 Employer 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	Agency/Writing Broker SSN	Is the Broker appointed with UHC? ☐ Yes ☐ No

Commissions Payable to:	Payee Code/Tax ID#	If more than 1 Broker % Production ______%

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 Employer 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.

450-4413 11/04
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A UnitedHealth Group Company

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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A UnitedHealth Group Company

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

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!