

# Employer Application for Small Business



Virginia

**UnitedHealthcare Insurance Company** ("The Company")  
185 Asylum Street, Hartford, CT 06103

**UnitedHealthcare Plan of the River Valley, Inc.** ("The Company")  
1300 River Drive, Suite 200, Moline, IL 61265

**UnitedHealthcare of the Mid-Atlantic, Inc.** ("The Company")  
800 King Farm Boulevard, Rockville, MD 20850

**Optimum Choice, Inc.** ("The Company")  
800 King Farm Boulevard, Rockville, MD 20850

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)

Internet access?

Yes  No

Contact Person

Email Address

# of Years  
in Business

Billing Address (If Different)

Telephone

Fax

Multi-Location Group\*

# Locations

Address(es) (or list on additional sheet of paper)

Yes  No

\*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

Organization Type  Partnership  C-Corp  S-Corp  LLC  LLP

Sole Proprietor  Other \_\_\_\_\_

Did you have any employees other than yourself and your spouse during the preceding calendar year?  Yes  No

Medical Benefit Plan Option

Calendar Year  
 Policy Year

Domestic Partner Coverage

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 for medical coverage cannot exceed 90 days)

Waiting Period for initial enrollees

Yes  No

Classes Excluded:  None  Union  Hourly

Non-Management  Salary

Nature of Business

Industry (SIC) Code

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

By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare Plan of the River Valley, Inc., or Optimum Choice, Inc.

Dental coverage provided by UnitedHealthcare Insurance Company

Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company

Vision coverage provided by UnitedHealthcare Insurance Company

Group Name \_\_\_\_\_

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		
# Hours per week to be eligible _____		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
# Hours per week to be eligible for Disability coverage if different from above ** _____		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
		LTD		LTD		LTD		
		Other		Other		Other		

**General Information (continued)**

Yes  No

**Subject to ERISA? (Most private sector plans are ERISA plans)**

If No, please indicate appropriate category:

Church (Additional information needed)  Federal Government

Indian Tribe – Commercial Business  Non-Federal Government (State, Local or Tribal Gov.)

Foreign Government/Foreign Embassy  Non-ERISA Other \_\_\_\_\_

**Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins 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\*
- No, we do not offer medical coverage during a leave of absence

**\*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.

**Consumer Driven Health Plan Options**

**Health Savings Account** (if selected): Which bank will be used:  OptumBank  Other

**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 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 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.



Group Name \_\_\_\_\_

**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. If the Group prefers hard copies of these documents and communications, I understand that I may contact the Company to make this request.

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 intentional misrepresentation, fraudulent statement, or omission that constitutes fraud 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, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, if applicable, are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established 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. 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 may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

**Signature**

Group Authorized Signature	Title	Date
----------------------------	-------	------

**Producer Information (if applicable)**

Writing Producer Name	Writing Producer SSN	Is the Producer appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
All Payments to:	CRID Code (for internal use)	Tax ID#	If more than 1 Producer*, Split _____%
Street Address	City	State	Zip Code
Producer Phone #	Producer Email Address	Producer Fax Number	

Yes  No To the best of my knowledge, acceptance of this application will replace existing life insurance coverage.

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.	<b>Producer Signature</b>	<b>Date</b>
--	---------------------------	-------------

\*If more than one Producer, provide the second Producer's information on an additional sheet of paper.

**UHC Sales Representative/Account Executive**

Sales Representative or Account Executive (First & Last Name)

**General Agent Information (if applicable)**

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