

Small Group Employer Application



To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Complete the Coverage and Benefit Options page(s) and attach to the application (if applicable).
4. Submit the most recent billing statement listing those currently insured and current status.
5. Submit most recent wage and tax statement.
6. Include a deposit check for the first month's premium.

Plan Design _____
Copayment _____
Coinsurance _____
Annual Deductible _____
Rx Option _____

<input type="checkbox"/> UnitedHealthcare Choice Plus
<input type="checkbox"/> UnitedHealthcare Select HMO
<input type="checkbox"/> UnitedHealthcare Managed Indemnity
<input type="checkbox"/> UnitedHealthcare Options PPO
<input type="checkbox"/> UnitedHealthcare Select Plus HMO
<input type="checkbox"/> UnitedHealthcare Options PPO 80/80
<input type="checkbox"/> [UnitedHealthcare Overture <input type="checkbox"/> Yes <input type="checkbox"/> No Overture Package _____ (A-S)]
<input type="checkbox"/> Healthy New York
UnitedHealthcare Dental Benefits
Dental Managed Indemnity <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Options PPO <input type="checkbox"/> Yes <input type="checkbox"/> No

General Information Requested Effective Date _____

Group Name _____			
Address _____		Tax ID _____	
City _____	State _____	Zip Code _____	County _____
Contact Person _____	Telephone (____) _____	Fax (____) _____	
Billing Address (if different) _____		Email Address _____	

Multi-location group? Yes No # of Locations _____ Address (please list locations on additional sheet) _____

# Years in Business/Date _____	Nature of Business _____	Industry Code/SIC Code _____
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Type of Organization C-Corporation Limited Liability Company Nonprofit Organization S-Corporation Independent Contractor Other _____ List names of eligible employees/dependents currently on COBRA/Continuation _____ See attached list

Total # Employees _____	# Full Time Employees _____	# Part Time Employees _____	# Applying (Please include those employees in their waiting period) _____	# Waiving _____	# Hours/week to be considered Eligible (Minimum 20-NY, 30-NJ) _____
# Termed in 12 months _____	Wait Period for New Hires <input type="checkbox"/> First of the policy month following _____ (0-180) days of employment <input type="checkbox"/> Effective _____ (0-180) days after the date of hire		Waiting Period Waived at Initial/Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No		# of Employees outside service area _____

Name of Current Medical Carrier _____	# Yrs Covered _____	Name of Current Dental Carrier _____	# Yrs Covered _____
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Employer Contribution – Single _____ % Medical Family _____ %	Employer Contribution – Single _____ % Dental Family _____ %	Classes Excluded <input type="checkbox"/> Union/Non Union <input type="checkbox"/> Other _____
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Worker's Comp Carrier _____	List Owners/Partners not covered by WC _____	Amount of deposit check _____
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Yes No In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

Yes No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be placed voluntarily into bankruptcy?

COBRA Continuation State Continuation Under federal law if your group had 20 or more employees 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 less than 20 employees, you must provide State Continuation.

Medicare Primary Health Plan Primary Under federal law if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary.

Yes No Are you a member of a "controlled group of corporations" as that term is defined by United States Code section 414(b) (Internal Revenue Code)? If yes, please give the legal names of all other corporations within the control group and the number of employees employed by each.

Broker Information

Broker Name	Agency	Agent Code	Tax ID Number
Signature	Email Address	Social Security #	Date
Rep Name	Rep #		

The Company certifies that the information provided above is complete and accurate. Company shall notify the Insurer promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under this Policy.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Company's employees.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependent who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the voiding or reformation of insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature (Form must be signed)

Signature _____ Date _____ Title _____

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