Key Account Insured Employer Application

UnitedHealthcare®

UnitedHealthcare Insurance Company of the River Valley

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. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

Coverage provided by "UnitedHealthCare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company of the River Valley
Dental, Vision and Disability coverage provided by UnitedHealthcare Insurance Company
Life insurance and AD&D coverage provided by UnitedHealthcare Insurance Company

General Information

Requested Effective Date _____

Group's/Company'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 | Telephone / Fax | Email Address

Billing Address (if different) | # of Years in Business

Multi-location group/company? ☐ Yes ☐ No | # of Locations | Address (es) (or list on additional sheet of paper)

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other _____ | Nature of Business | Industry Code

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

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

ERISA Plan? ☐ Yes ☐ No

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)

Number of Employees Termed in last 12 Months

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary

Have Workers' Comp? ☐ Yes ☐ No | Name of Workers' Compensation Carrier | Domestic Partner Coverage? ☐ Yes ☐ No

Names of Owners/Partners not covered by Workers' Compensation

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

Participation

Eligible Employees
Ineligible Employees
Total # Employees

Hours per week to be eligible _____

Hours per week to be eligible for Disability coverage if different from above ** _____

**For Disability products the minimum # of work hours per week to be eligible is 30 hours.

	# Employees Applying for:	# Employees Waiving for:	Contribution	Employer %	Employer % for Dep
Medical					
Dental					
Vision					
Basic EE Life/AD&D					
Basic Dep Life					
Supp EE Life/AD&D					
Supp Dep Life/AD&D					
STD					
STD Buy Up					
LTD					
LTD Buy Up					
Other					

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Dental, Vision and Disability coverage provided by UnitedHealthcare Insurance Company
Life insurance and AD&D coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

Optional Benefits: Option selected applies to all plans.

☐ Yes ☐ No	Chemical Dependency Treatment
☐ Yes ☐ No	(Religious employer Groups Only) Do you wish to remove contraceptive drugs or devices from the prescription drug coverage subject to (NCGS) 58-3-178(e)?
☐ Yes ☐ No	In the past 36 months, has the Group/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 Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ Yes ☐ No	Is your group a Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.
☐ Yes ☐ No	Do you currently utilize the services of a Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?

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.

Optional Benefits: Option selected applies to all plans.

☐ Yes ☐ No Chemical Dependency Treatment

☐ Yes ☐ No (Religious employer Groups Only) Do you wish to remove contraceptive drugs or devices from the prescription drug coverage subject to (NCGS) 58-3-178(e)?

HRA and Supplemental Insurance Information

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.

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? ☐ Yes ☐ No

Who will provide account balances to UnitedHealthcare?

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___/___ End Date___/___/___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

☐ Yes ☐ No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

☐ Yes ☐ No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

☐ Yes ☐ No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

☐ Yes ☐ No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

☐ Yes ☐ No 6. Is any employee or dependent currently hospitalized?

☐ Yes ☐ No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?

- ☐ Cancer (any type)
- ☐ Lung disease or respiratory problem (any type)
- ☐ Heart disease or disorder (any type)
- ☐ Organ, tissue or cell transplant
- ☐ Liver disease (any type)
- ☐ Kidney disease (any type)
- ☐ Pancreatic disorder (any type)
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Morbid obesity
- ☐ Congenital abnormality
- ☐ Vascular disease (any type)
- ☐ Neurological disorder (any type)
- ☐ Immunological disorder (reportable types)
- ☐ Alcohol or drug addiction or abuse
- ☐ Hemophilia or Blood disorder (any type)

If you have answered "Yes" to any of the questions above, please provide the requested information on the next page for each individual. If necessary, use additional sheets of paper.

Disclosures (continued)

Question Number	Check One Employee	Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Current Treatment

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates 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, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates 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 the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, in the information requested on this form can result in the adjustment of rating or voiding of insurance.

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

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information, or conceals information for the purpose of misleading, in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
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. We may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions 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.

Signature (Form must be signed)

Group/Company Signature _____ **Date** _____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

Broker Name	Agency	Agent Code/Tax ID Number

Signature	Email Address	Social Security #	Phone Number	Date

Commissions payable to	Broker Commission Schedule _____ Std Scale of _____ %

Street Address	City	State	Zip Code

Rep Name	Rep #