

# 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/covered 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.**

Unimerica Life Insurance Company

<b>General Information</b>				Effective Date
Group's Legal Name				Tax ID
DBA, if applicable				
Group name to appear on ID card (maximum 30 characters and spaces)				
Address				Start Date of Business
City		State		Zip Code
Billing Contact / Title		Telephone	Fax	E-mail Address
Billing Address (If different)				
Executive Contact / Title		Telephone	Fax	E-mail Address
Administrative / Service Contact / Title		Telephone	Fax	E-mail Address
Organization Type: <input type="checkbox"/> Partnership <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC/LLP <input type="checkbox"/> Ind. Contractor <input type="checkbox"/> Non-Profit <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other			Nature of Business	Industry (SIC) Code
Multi-Location Group <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Locations	Address(es) (Use additional sheet of paper if necessary)		
#of hours per week to be eligible	Classes Excluded (if applicable): <input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly (# of hours _____ ) <input type="checkbox"/> Non-Management	Waiting Period for New Hires		Waiting Period for Rehire
		<input type="checkbox"/> 1st of the month following Date of Hire <input type="checkbox"/> 1st of the month following _____ [months] [days] of employment <input type="checkbox"/> Date of Hire (no waiting period) <input type="checkbox"/> _____ [months] [days] of employment following Date of Hire		<input type="checkbox"/> 1st month following _____ months <input type="checkbox"/> Yes <input type="checkbox"/> No
Have Workers' Comp <input type="checkbox"/> Yes <input type="checkbox"/> No		Workers' Comp Carrier Name		
Subject to ERISA Regulation <input type="checkbox"/> Yes <input type="checkbox"/> No		Workers' Comp – Reason if no coverage		
Names of Owners/Partners not covered by Workers' Comp:				
Name	Title	Telephone	Fax	E-mail Address
Name	Title	Telephone	Fax	E-mail Address
Names of Persons currently on COBRA/Continuation:				
Name	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	<input type="checkbox"/> COBRA-AB1401	COBRA Qualifying Event	COBRA Date of Qualifying Event
Name	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	<input type="checkbox"/> COBRA-AB1401	COBRA Qualifying Event	COBRA Date of Qualifying Event
Name	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	<input type="checkbox"/> COBRA-AB1401	COBRA Qualifying Event	COBRA Date of Qualifying Event
Name	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	<input type="checkbox"/> COBRA-AB1401	COBRA Qualifying Event	COBRA Date of Qualifying Event

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.**

Coverage provided by "UnitedHealthcare and Affiliates": Medical coverage provided by United HealthCare Insurance Company. Dental coverage provided by United HealthCare Insurance Company, Unimerica Life Insurance Company or Dental Benefit Providers of California, Inc. Life Insurance coverage provided by United Healthcare Insurance Company or Unimerica Life Insurance Company. Vision coverage provided by United Healthcare Insurance Company or Unimerica Life Insurance Company. Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by PacifiCare Health Plan Administrators, Inc., Prescription Solutions or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

## General Information (continued)

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

Name of Current Medical Carrier <input type="checkbox"/> None	Begin Date End Date	Name of Current Dental Carrier <input type="checkbox"/> None	Begin Date End Date
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### Leave of Absence:

How long do you continue paying health care premiums for employees on leave of absence? (maximum of six months):

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or voluntary or involuntary supplemental medical insurance alongside a UnitedHealthcare medical plan? Answers must be accurate whether purchased from UnitedHealthcare or any other insurer/health care service plan or third-party administrator.

1. HRA  Yes  No If yes, please identify type:  Definity<sup>SM</sup> Select HRA  Other Administrator HRA

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 (HRA).

2. Supplemental Insurance/Health Plan Coverage  Yes  No

Supplemental medical insurance is not permitted alongside any UnitedHealthcare plan. If answered "Yes" for Supplemental, coverage will not be approved. If answered "No", and purchased subsequently, coverage is subject to termination.

## Participation

	# Applying for:	# Waiving for:	Contribution	Employer %	Employee%	Employer % for Dep
# Full-Time (30+ Hours) Eligible Employees Enrolling in CA	Medical	Medical	Medical			
# Part-Time (20-29 Hours) Eligible Employees Enrolling in CA	Life	Life	Life			
# Full-Time (30+ Hours) Eligible Employees Enrolling Outside of CA	Dental	Dental	Dental			
# Part-Time (20-29 Hours) Eligible Employees enrolling Outside of CA	Vision	Vision	Vision			
# Employees in Waiting Period	Other	Other	Other			
Total # Employees Waiving						
# Ineligible Employees (other than noted above)						
Total # Employees						

## Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation (e.g., Cal-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. If your group had fewer than 20 employees, you must provide State 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 *Evidence of Coverage*, *Certificate of Coverage* or *Summary Plan Description*, and other documents, notices and communications regarding the coverage indicated on this application, herein referred to as "Disclosure Materials," will be transmitted electronically to the Group/Company.

I acknowledge and affirmatively agree, on behalf of the Group/Company, to provide the applicable Disclosure Materials provided by UnitedHealthcare and Affiliates that contain information regarding benefits, services, exclusions, limitations and terms of the enrollee's health care coverage in electronic form and/or hard copy to enrolled members in accordance with California and federal laws, so as to afford the enrollee full and fair disclosure.

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, material misrepresentation or intentional, material omission may result in rescission of the group/company policy/agreement, termination of coverage, or increase in premiums retroactive to the original effective date of the agreement/policy. UnitedHealthcare will issue a written notice explaining the basis for the decision of rescission and your appeal rights.** Group/Company will receive any notices for failure to pay and/or termination in writing. In accordance with the Group Subscriber Agreement/Policy, Group is delegated to provide notice of termination to each subscriber/insured person at the subscriber's/insured person's current address. For nonpayment of premiums, UnitedHealthcare and Affiliates will send a notice of termination with appeal rights directly to the member.

Any person who knowingly and with intent to defraud any insurance company/health care service plan or other person files an application for insurance/health plan coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance or health plan coverage act, which is a crime.

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**Important Information (continued)**

UnitedHealthcare 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/health plan coverage 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. 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/agreements (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 pursuant to federal law. 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 [www.uhc.com](http://www.uhc.com) and click on the dropdown box for employers under “View Our Programs – Producer Payment Programs.”

For specific information about the compensation payable with respect to your particular policy/agreement, please contact your producer.

**BINDING ARBITRATION**

**I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE § 1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. SEC. 1, ET SEQ.**

Authorized Signer for Group (Name - Required)	Title (Required)
Signature (Required)	Date (Required)

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**Commission Information**

Writing Broker Name			Writing Broker SSN		
Holds Current Appointment with <input type="checkbox"/> UnitedHealthcare	Payee CA License #	Payee CA License Expiration Date	Writing Agent's License #	Writing Agent's License Expiration Date	
Commissions Payable to:		Payee Code	CRID Code	Tax ID#	If more than one Broker*, Split _____%
Street Address		City		State	Zip Code
Broker Phone #	Broker Fax Number		Broker E-mail Address		
<p>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.</p> <p><b>Health Reimbursement Accounts ("HRA") and Self-Funded Plans.</b> UnitedHealthcare prohibits the solicitation of its medical products for use in conjunction with HRA or self-funded plans unless the medical product is specifically designed for such use. If UnitedHealthcare determines that Producer solicited a medical product for use with an HRA or self-funded plan that was not specifically designed for use with an HRA or self-funded plan, UnitedHealthcare reserves the right to withhold commissions for such business and Producer shall repay UnitedHealthcare, on demand, the amount of commissions Producer received for such business. UnitedHealthcare reserves the right to deduct recoverable commissions from any other commissions due Producer from UnitedHealthcare or any of its parents, subsidiaries or affiliates.</p>					
Broker Signature				Date	

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

**General Agent Override Information**

General Agent	General Agent Tax ID#	Phone #	Franchise Code		
Street Address	City		State	Zip Code	
Contact Name	E-mail Address				

**Admin Kit**

Send Admin Kit To:	Address
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