

Insured 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. Include a deposit check in the amount of the estimated first month's premium; 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.

General Information

Requested Effective Date _____

Group's/Company's Legal Name

Street Address		Tax ID	
City	State	Zip Code	County
Contact Person	Telephone	Fax	Email Address

Billing Address (if different)

Multi-location group/company? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Locations	Address (es) (or list on additional sheet of paper)
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# of Years in Business	Nature of Business	Industry Code
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# Hours per week to be eligible	Waiting Period for new hires	<input type="checkbox"/> 1st of Policy Month following Date of Hire	Waiting Period waived for initial enrollees <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> 1st of Policy 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"/> Other _____	

Number of Persons currently on COBRA/Continuation: (employees/dependents)	Number of Employees Termed in last 12 Months	Classes Excluded: <input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Management <input type="checkbox"/> Non-Owners
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Participation	# Applying for:	# Waiving for:	Contribution	Employer %	Employee%	Employer % for Dep
# Full Time Employees	Medical	Medical	Medical			
# Part Time Employees	Life	Life	Life			
# Ineligible Employees	Dental	Dental	Dental			
Total # Employees	Vision	Vision	Vision			
	Other	Other	Other			

Name of Current Medical Carrier	# Yrs with the Current Carrier	Name of Current Dental Carrier	# Yrs with the Current Carrier
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Name of Worker's Comp Carrier	Names of Owners/Partners not covered by Workers Compensation
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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?

Note: Life Insurance premiums for totally disabled insureds are waived for 6 months.

Yes No Acceptance of this application will replace existing life insurance coverage.

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.

Dental coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.

Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

Agent Information

Agent Name		Agency		Agent Code/Tax ID Number	
Printed Agent Name		Email Address	Social Security #		Phone Number
Rep Name		Rep #			
Commissions payable to			Agent Commission Schedule _____ Std Scale of _____ %		
Agent Signature			Florida License ID#		

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

*See next page for important disclosure regarding agent compensation.

Disclosures

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). 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 5 years, has an 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 5 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 5 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 5 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 5 years, has any employee or dependent had a hospital stay lasting more than 5 days?
- Yes No 6. Is any employee or dependent currently hospitalized?
- Yes No 7. Except for allergy-related, birth-control or infertility medication, during the past 5 years, has any employee or dependent taken a prescription medication for a period lasting more than 6 months?
- Yes No 8. Is any employee or dependent currently taking a prescription medication that will be taken for more than 6 months?
- Yes No 9. During the past 5 years, has any employee or dependent been treated for OR diagnosed by a physician as having one of the following conditions:
- | | |
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| <input type="checkbox"/> Cancer (any type)
<input type="checkbox"/> Lung disease or respiratory problem (any type)
<input type="checkbox"/> Heart disease or disorder (any type)
<input type="checkbox"/> Organ, tissue or cell transplant
<input type="checkbox"/> Liver disease (any type)
<input type="checkbox"/> Kidney disease (any type)
<input type="checkbox"/> Pancreatic disorder (any type)
<input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis
<input type="checkbox"/> Morbid obesity
<input type="checkbox"/> Congenital abnormality
<input type="checkbox"/> Vascular disease (any type)
<input type="checkbox"/> Neurological disorder (any type)
<input type="checkbox"/> Immunological disorder (reportable types)
<input type="checkbox"/> Alcohol or drug addiction or abuse |
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If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

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

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 material omissions misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

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 agent compensation:

We pay agents compensation for their services in connection with the sale of our insured 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. In general, our total bonuses are less than 10% of total agent compensation paid. It is our policy not to pay commissions to agents with respect to a product for which the customer is also paying the agent a commission or other fee. Please note we also make payments from time to time to agents for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Agent 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. We also have taken steps to ensure that agents properly disclose their compensation arrangements to their customers, but we cannot guarantee the agent's compliance. For general information on our agent payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to <http://www.uhc.com> and click on the drop down box for employers under "View Our Programs - Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your agent.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature (Form must be signed)

Group/Company Signature _____ Date _____ Title _____

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