

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.

- UnitedHealthcare Choice
- UnitedHealthcare Choice Plus
- UnitedHealthcare Select
- UnitedHealthcare Select Plus
- UnitedHealthcare Options PPO
- UnitedHealthcare Options PPO 80/80
- UnitedHealthcare Managed Indemnity
- [UnitedHealthcare Rhapsody]
- [UnitedHealthcare Overture Yes No Overture Package _____ (A-S)]
- UnitedHealthcare Dental Benefits**
- Dental Managed Indemnity Yes No
- Dental Options PPO Yes No
- Dental Select DHMO Yes No
- [Vision Benefits**
- Quality Yes No
- Elite Yes No
- Life/AD&D Benefits**
- Dependent Life Yes No
- Supplemental Life Yes No
- Supplemental AD&D Yes No
- Critical Illness Rider Yes No

General Information		Requested Effective Date _____	
Group Name _____			
Address _____		Tax ID _____	
City _____		State _____	Zip Code _____ County _____
Contact Person _____	Title _____	Telephone (____) _____	Fax (____) _____
Billing Address (if different) _____			Email Address _____
Multi-location group? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Locations _____	Address (please list locations on additional sheet) _____	
# Years in Business _____	Nature of Business _____	Industry Code _____	
Type of Organization <input type="checkbox"/> C-Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Nonprofit Organization <input type="checkbox"/> S-Corporation <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other _____	List names of eligible employees/dependents currently on COBRA/Continuation _____ <input type="checkbox"/> See attached list		
Total # Employees _____	# Full Time Employees _____	# Part Time Employees _____	# Applying (Please include those employees in their waiting period) _____
# Termed in 12 months _____	# Waiving _____	# Hours per week to be Considered Eligible _____	# of Employees outside service area _____
Wait Period for New Hires – First of the month following _____ days of employment		Waiting Period Waived at Initial/Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Current Medical Carrier _____ # Yrs Covered _____		Name of Current Dental Carrier _____ # Yrs Covered _____	
Employer Contribution – Single _____% Medical Family _____%		Employer Contribution – Single _____% Dental Family _____%	
Employer Contribution – Single _____% Life Dependents _____%		Classes <input type="checkbox"/> Union/Non Union <input type="checkbox"/> None Excluded <input type="checkbox"/> Other _____	
Worker's Comp Carrier _____		List Owners/Partners not covered by WC _____	Amount of deposit check _____
<input type="checkbox"/> Yes <input type="checkbox"/> 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)		
<input type="checkbox"/> Yes <input type="checkbox"/> 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?		
<input type="checkbox"/> COBRA Continuation <input type="checkbox"/> 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.		
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> 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.		
<input type="checkbox"/> Yes <input type="checkbox"/> 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 Assurance Benefits PO Box 41454 Phx 85080	Agent Code/Tax ID Number
Signature	Email Address	Social Security #	Date
Rep Name		Rep #	

Medical Profile

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. Have any employees or dependents been diagnosed or treated during the past five years for:

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizures	<input type="checkbox"/> Kidney Disease/Kidney Failure	<input type="checkbox"/> Back Disorders
<input type="checkbox"/> Chronic Lung Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV+
<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Mental/Nervous Disorder	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Congenital Disorders	<input type="checkbox"/> Growth Hormones	<input type="checkbox"/> Intestinal Disorders
<input type="checkbox"/> Liver Disorders	<input type="checkbox"/> Organ Transplants	<input type="checkbox"/> Connective Tissue Disorder

- Yes No 2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births.
- Yes No 3. Have any employees or dependents been hospitalized or had any surgical operations during the past 5 years?
- Yes No 4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?
- Yes No 5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?
- Yes No 6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation, Medicare and Medicaid.

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

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.

Signature (Form must be signed)

Signature _____ Date _____ Title _____

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