

EMPLOYER GROUP APPLICATION

UnitedHealthcare of Arizona, Inc.
3141 North 3rd Avenue
Phoenix, AZ 85012

CHOICE Plus products offered by UnitedHealthcare Insurance Company and UnitedHealthcare of Arizona, Inc.

Life and Dental products offered by
 UnitedHealthcare Insurance Company

FOR PLAN USE ONLY	
Please circle the appropriate answer to the following questions. The "group" is defined as the entity who will be paying the monthly bill	
Y/N	This group has fewer than 30 eligible employees.
Y/N	This group is defined as a "small group" according to state regulation.
Y/N	The employees of this group will complete medical questions at initial enrollment.
Act Group Effective Date: _____ End Date: _____ ACH: _____	

APPLICATION INSTRUCTIONS

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 NOTIFICATION OF APPROVAL.**
3. Complete the Coverage and Benefit Options page(s) and attach to the application.
4. Submit the most recent premium statement listing those currently insured and current rates.
5. Submit last quarterly wage and tax statement.
6. Include deposit check for the first month's premium.
7. Individual applications may be requested for groups less than 50 EE and groups with no prior coverage.

GROUP INFORMATION

1. Company Name		<input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship	
<input type="checkbox"/> Partnership			
2. Federal Identification Number	3. Contact Name		4. Title
5. Street Address		6. City	
7. County	8. State	9. Zip Code	10. Phone Number
11. Fax Number			
12. Billing Address		13. City	14. State AZ
15. Zip Code		16. Worker's Compensation Carrier	
		17. List any employee classes excluded from coverage <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Other _____	
18. Application for (check all that apply and attach the completed benefit option checklist) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Major Medical (out-of-area)			
19. # of Yrs Company in Business	20. Nature of Business		21. Standard Industry Code
22. In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be voluntarily into bankruptcy?			YES NO <input type="checkbox"/> <input type="checkbox"/> YES NO <input type="checkbox"/> <input type="checkbox"/>
23. Total # of Employees (include those in waiting period) _____ Full-time (30 hrs/wk) _____ Part-time		24. Total # of eligible employees?	25. Total # of employees applying?
26. # of Employees Terminated in last 12 months?	27. Requested effective date?		28. Effective date for new hires: First of the month following the completion of _____ day waiting period.
29. List Employees/Dependents on COBRA.		30. Previous carriers in past 5 years?	
31. Minimum number of hours worked per week to be eligible _____ (Minimum of 30 hrs/wk)		32. Employer Contribution MEDICAL _____ % Single _____ % Dependents DENTAL _____ % Single _____ % Dependents LIFE _____ % Single _____ % Dependents	

PLEASE ANSWER THE 5 QUESTIONS. EXPLAIN ANY "YES" ANSWERS BELOW.

To the best of your knowledge:

1. Has any employee/dependent been treated for a serious illness (physical or mental), had more than \$5,000 of medical expenses, been hospitalized or had surgery in the past 12 months? YES
 NO
2. Is any employee/dependent apt to have a continuing claim from any existing mental or physical disorder, including pregnancy? YES
 NO
3. Has any employee/dependent been advised to have surgery in the last six months or anticipate hospitalization for any other reason? YES
 NO
4. Are there any employees/dependents who are incapacitated or confined in a hospital or treatment facility? YES
 NO
5. Are there any employee/dependents who are not actively performing their duties full-time due to a disabling illness or injury? YES
 NO

IMPORTANT – PLEASE READ CAREFULLY

The Company certifies that the information provided above is complete and accurate. The 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 hired eligible employees or dependents. UnitedHealthcare of Arizona, Inc. shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy.

During and after termination of the Policy, Company grants UnitedHealthcare of Arizona permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in UnitedHealthcare of Arizona's possession. The parties shall maintain the confidentiality of any information related to Covered Persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without the prior written consent of that party.

It is understood and agreed that: 1) renewal rates will be based on several factors which may include, but are not limited to, the projected future claims experience or your group, except where prohibited by law; 2) insurance will be effective only on the date specified by UnitedHealthcare of Arizona after the application has been approved by UnitedHealthcare of Arizona and the first full premium has been paid. The Company's cancelled check is a receipt of the deposit. The group coverage has been approved and issued.

EMPLOYER SIGNATURE: _____ DATE: _____

TITLE: _____ AMOUNT OF DEPOSIT: \$ _____

BROKER AGREEMENT

For Plan Use Only

Broker Name		Broker #		Sales Rep Name	
Agency Name	Phone No () Fax No ()	Broker Commission Schedule _____ Std Scale _____ % Flat		Sales Rep #	
Address		City	State	Zip Code	
Commission Payable To			Tax ID/SSN		

Broker Signature: _____ Date: _____