

(DO NOT STAPLE)



# Joint Health and Life Employer Application

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 and current status
- 4 Submit most recent wage and tax information
- 5 Include a deposit check for the first month's premium

**Administering Office Address**  
 2795 E. Cottonwood Pkwy, Ste. 200  
 Salt Lake City, Utah 84121  
 (800) 624-2942

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

Requested Eff Date

## General Information

Group Name \_\_\_\_\_

Address \_\_\_\_\_ Tax ID \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact Person \_\_\_\_\_ Telephone \_\_\_\_\_ Email Address \_\_\_\_\_

Billing Address (If Different) \_\_\_\_\_ Industry Code \_\_\_\_\_

Organization Type  Partnership  Corp  LLC/LLP  Ind. Contractor  Non-Profit  Other \_\_\_\_\_ Nature of Business \_\_\_\_\_

Multi-Location Group  Yes  No # Locations \_\_\_\_\_ Address(es) (or, list on additional sheet of paper) \_\_\_\_\_

List Names Currently on COBRA/Continuation  See Attached List  None Waiting Period for new hires  Date of Event  1st of policy month following \_\_\_\_\_ months of employment

Have Worker's Comp  Yes  No List Owners/Partners not covered by Workers' Comp \_\_\_\_\_

Waiting period waived at initial enrollment  Yes  No # Hours per week to be eligible \_\_\_\_\_ Classes Excluded  None  Union  Other \_\_\_\_\_

Participation	# Applying for:	# Waiving for:	Name of Current Carrier	Contribution			Employer % for Dep
				Product	Employer %	Employee%	
# Full Time Employees	Health	Health		Health			
# Part Time Employees	Life	Life		Life			
# Ineligible Employees	Dental	Dental		Dental			
Total # Employees	Vision	Vision		Vision			
	Other	Other		Other			

## Questions Regarding Group Size

COBRA  St Continuation Under federal law, if your group had 20 or more employees on your payroll 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 fewer than 20 employees, you must provide State Continuation.

Medicare Primary  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.

Yes  No Are you a member of a "controlled group of corporations" as that term is defined by United States Internal Revenue Code section 414(b). If yes, please give the legal names of all other corporations within the controlled group and the number of employees employed by each.

Life Coverage Provided by United HealthCare Insurance Company (domiciled Hartford, CT)  
 Health Coverage Provided by United HealthCare Insurance Company or United HealthCare of Utah (domiciled Salt Lake City, UT)

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Company's employees.

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 the Insurer(s) will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

NOTE: We pay brokers and agents (referred to collectively as "producers") 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 producer compensation paid. 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 (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. 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 <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 producer.

Employer Signature		Title	Date
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Writing Broker Name		Agency/Writing Broker SSN	Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Commissions Payable to:		Payee Code/Tax ID#	If more than 1 Broker % Production _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	
The contents of this application were fully explained during a meeting with the Employer submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.		Broker Signature	Date

For the Second Broker / Agent (if Applicable)

Writing Broker Name		Agency/Writing Broker SSN	Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Commissions Payable to:		Payee Code/Tax ID#	If more than 1 Broker % Production _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	
The contents of this application were fully explained during a meeting with the Employer submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.		Broker Signature	Date

[Redacted]		[Redacted]	
General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code
[Redacted]		[Redacted]	
Send Admin Kit To:	Address		