

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
- 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.

For 10-50 Size Groups age-banded rates composite rates Groups with 10-50 employees may choose composite rates and/or age-banded rates; composite rates will be provided unless age-banded rates are requested. Groups with nine or less eligible employees will be provided age-banded rates.

Health Coverage Provided by United HealthCare Insurance Company or United HealthCare of Colorado, Inc.
Life Coverage Provided by United HealthCare Insurance Company

Important Information

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.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Signature

Employer Signature	Title	Date
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Commission Information

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
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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
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General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address
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