

Small Business Employer Application (2-50 employees)

UnitedHealthcare of Ohio, Inc. / United HealthCare Insurance Company [of Ohio]



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.
7. Please print clearly, using black ink.

General Information

Requested Effective Date _____

Group Name _____

Address		Tax ID	
City	State	Zip Code	County
Contact Person	Telephone ()	Fax ()	
Billing Address (if different)		Email Address	

Multi-location group? # of Locations Address (please list locations on additional sheet)
 Yes No

# Years in Business	Nature of Business	Industry Code
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Type of Organization C-Corporation Limited Liability Company Nonprofit Organization S-Corporation Independent Contractor Other _____ List names of eligible employees/dependents currently on COBRA/Continuation _____ See attached list

Total # Employees	# Full Time Employees	# Part Time Employees	# Applying (Please include those employees in their waiting period)	# Waiving	# Outside service area
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# Termined in 12 months	Wait Period for New Hires <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	Date of Event	Waiting Period Waived at Initial/Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Current Medical Carrier	# Yrs Covered	Name of Current Dental Carrier	# Yrs Covered
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Employer Contribution – Single ___% Medical Family ___%	Employer Contribution – Single ___% Dental Family ___%	Employer Contribution – Single ___% Life Family ___%	Classes <input type="checkbox"/> Union/Non Union Excluded <input type="checkbox"/> Other _____
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Worker's Comp Carrier	List Owners/Partners not covered by WC	Amount of Deposit
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Yes 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)

Yes 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?

COBRA Continuation 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.

Medicare Primary 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.

Yes 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 Benefits Network	Agent Code/Tax ID Number AS516 / 31-1273990	
Signature	Social Security #	Broker Email Address	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	
	Employee	Dependent						Current Treatment	

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 dependents who have elected continuation of insurance benefits. Submission of any application or filing a claim containing false or deceptive statements with intent to defraud or facilitate a fraud against an insurer constitutes insurance fraud.

Company agrees to contribute a minimum of 50% of the employee premium.

Signature (Form must be signed)

Signature _____ Date _____ Title _____

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

Central Ohio
9200 Worthington Road
Westerville, OH 43082-8823
(614) 410-7000 (800) 328-8835
Fax (614) 410-7449

Northern Ohio
1375 East 9th Street, Suite 700
Cleveland, OH 44114
(216) 420-4080 (800) 468-5001
Fax (216) 420-9429

Southwest Ohio
9050 Centre Point Drive, Suite 400
West Chester, OH 45069
(513) 603-6200 (866) 351-6827
Fax (513) 603-6273

SW Ohio Medical Benefit Options

Directions: Please select a medical plan and a pharmacy plan from the options listed.

Medical Plan Options <i>(Local Ohio WR Pinnacle PPO and OH Plus Plans)</i>			Pharmacy Options <i>(All Rx options include oral contraceptives and mail order benefit)</i>
<input type="checkbox"/> WR-A	<input type="checkbox"/> OJ-A	<input type="checkbox"/> ON-A	<input type="checkbox"/> F5 - \$10/25/45
<input type="checkbox"/> WR-B	<input type="checkbox"/> OJ-B	<input type="checkbox"/> ON-B	<input type="checkbox"/> H9 - \$10/30/50
<input type="checkbox"/> WR-C	<input type="checkbox"/> OJ-C	<input type="checkbox"/> OH-A	<input type="checkbox"/> G4 - \$10/30/50 with \$100/\$300 annual deductible
<input type="checkbox"/> WR-D	<input type="checkbox"/> OJ-D	<input type="checkbox"/> OH-B	<input type="checkbox"/> S8 - \$10/30/50 with \$250/\$750 annual deductible
<input type="checkbox"/> WR-E	<input type="checkbox"/> OJ-E	<input type="checkbox"/> OH-C	<input type="checkbox"/> 1A - \$45/30/15 with \$2,000/6,000 max annual OOP
<input type="checkbox"/> WR-F	<input type="checkbox"/> OJ-F	<input type="checkbox"/> OH-D	<input type="checkbox"/> 1B - \$10/25/40 with \$2,500/7,500 max annual OOP
<input type="checkbox"/> WR-I	<input type="checkbox"/> OJ-G	<input type="checkbox"/> OH-E	
<input type="checkbox"/> WR-J	<input type="checkbox"/> OJ-H	<input type="checkbox"/> OH-Q	
<input type="checkbox"/> WR-K	<input type="checkbox"/> OM-A	<input type="checkbox"/> OH-R	
	<input type="checkbox"/> OM-B	<input type="checkbox"/> OH-S	

Medical Plan Options <i>(Enterprise National Options PPO)</i>			Pharmacy Options <i>(All Rx options include oral contraceptives and mail order benefit)</i>
<input type="checkbox"/> US-A	<input type="checkbox"/> US-M	<input type="checkbox"/> US-X	<input type="checkbox"/> K4 - \$10/25/40
<input type="checkbox"/> US-B	<input type="checkbox"/> US-N	<input type="checkbox"/> US-Y	<input type="checkbox"/> H9 - \$10/30/50
<input type="checkbox"/> US-C	<input type="checkbox"/> US-O	<input type="checkbox"/> US-Z	<input type="checkbox"/> 2V - \$10/30/60
<input type="checkbox"/> US-D	<input type="checkbox"/> US-P	<input type="checkbox"/> AN-A	<input type="checkbox"/> G4 - \$10/30/50 with \$100/\$300 annual deductible
<input type="checkbox"/> US-E	<input type="checkbox"/> US-Q	<input type="checkbox"/> AN-B	<input type="checkbox"/> S8 - \$10/30/50 with \$250/\$750 annual deductible
<input type="checkbox"/> US-F	<input type="checkbox"/> US-R	<input type="checkbox"/> AN-C	
<input type="checkbox"/> US-G	<input type="checkbox"/> US-S	<input type="checkbox"/> AN-D	
<input type="checkbox"/> US-H	<input type="checkbox"/> US-T	<input type="checkbox"/> ND-A	
<input type="checkbox"/> US-I	<input type="checkbox"/> US-U	<input type="checkbox"/> ND-B	
<input type="checkbox"/> US-J	<input type="checkbox"/> US-V	<input type="checkbox"/> ND-C	
<input type="checkbox"/> US-K	<input type="checkbox"/> US-W	<input type="checkbox"/> ND-D	
<input type="checkbox"/> US-L			

Medical Plan Options <i>(Indemnity Series – Non differential Plans)</i>		Pharmacy Options <i>(All Rx options include oral contraceptives and mail order benefit)</i>
<input type="checkbox"/> CW-G		<input type="checkbox"/> K4 - \$10/25/40
<input type="checkbox"/> CW-H		<input type="checkbox"/> H9 - \$10/30/50
<input type="checkbox"/> CW-I		<input type="checkbox"/> 2V - \$10/30/60
<input type="checkbox"/> CW-J		<input type="checkbox"/> G4 - \$10/30/50 with \$100/\$300 annual deductible
<input type="checkbox"/> CW-K		<input type="checkbox"/> S8 - \$10/30/50 with \$250/\$750 annual deductible
<input type="checkbox"/> CW-L		
<input type="checkbox"/> CW-M		

Dual Option Plans- Please contact your Account Executive for details	
Plan One:	Plan Two:
Medical Plan choice _____	Medical Plan choice _____
Rx Plan choice _____	Rx Plan choice _____

-Additional Medical Plan Options Listed on back-

Are you a SOCA Chamber of Commerce Member?

Yes No

If yes, which chamber: _____

SOCA Medical Plan Options <i>(Southern Ohio Chamber Alliance Pinnacle PPO & Plus Plans)</i>		Pharmacy Options <i>(All Rx options include oral contraceptives and mail order benefits)</i>
<input type="checkbox"/> OH-M	<input type="checkbox"/> WR-G	<input type="checkbox"/> H9 - \$10/30/50
<input type="checkbox"/> OH-N	<input type="checkbox"/> WR-H	<input type="checkbox"/> G4 - \$10/30/50 with \$100/\$300 annual deductible
		<input type="checkbox"/> S8 - \$10/30/50 with \$250/\$750 annual deductible

Ancillary Product Options

Directions: Please select any ancillary production options from the options listed below.

Dental Plan Options		
<input type="checkbox"/> P0014 Passive PPO w/Ortho	<input type="checkbox"/> P0058 Passive PPO	<input type="checkbox"/> P0061 Incentive PPO w/Ortho
<input type="checkbox"/> P0015 Passive PPO	<input type="checkbox"/> P0059 Passive PPO	<input type="checkbox"/> P1213 Voluntary
<input type="checkbox"/> P0042 Passive PPO	<input type="checkbox"/> P0060 Incentive PPO	<input type="checkbox"/> P1223 Voluntary w/Ortho

Life Insurance (Including AD&D) Plan Options		
<input type="checkbox"/> Flat Amount \$ _____	<input type="checkbox"/> Flat Amount / Class Type	Dependent Life Options
<input type="checkbox"/> _____ X Salary (attach salary list)	Class 1 \$ _____ / _____	<input type="checkbox"/> \$2,000 spouse \$1,000 child
	Class 2 \$ _____ / _____	<input type="checkbox"/> \$4,000 spouse \$2,000 child
	Class 3 \$ _____ / _____	<input type="checkbox"/> \$7,500 spouse \$3,750 child

Standard Vision Plan *(Included in all medical plans)*

Administrative Guidelines

Direction: Please select the effective date for new hires from the guidelines below.

Effective Date for Event Administration: New Hires, terminations, re-hire/ return to work <i>(Maximum waiting period in Ohio is ninety [90] days if you employ 2-50 employees.)</i>	
Select One From the Following:	Select one from the following:
<input type="checkbox"/> Date of Event	<input type="checkbox"/> None <input type="checkbox"/> 2 Months
<input type="checkbox"/> First of month following completion of:	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months

Standard Eligibility and Administrative Provisions for Policies in Ohio:

- | | |
|--|---|
| ⇒ Dependent Age Limit: Age 19 – End of month | ⇒ Type of Continuation Coverage: COBRA/State Continuation
<i>(based on group size)</i> |
| ⇒ Full-Time Student Dependent Age Limit: Age 25 – End of month | ⇒ Billing Frequency: Monthly |
| ⇒ Effective Date for Qualifying Event: Date of event | ⇒ Payment Due Date: First of the policy month |
| ⇒ Rate Calculation: Subject to change upon renewal | |
| ⇒ Rehire/Return to work follows Event Administration | |

Group Name: _____ Effective Date: _____

Group Signature: _____ Date: _____

Scheduled Direct Debit Authorization Form

Enrollment Instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.

STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Debit, I agree to and/or understand all of the following on behalf of my group:

It may take up to one month to establish this process. If a customer is overdue on a prior bill, a delinquency letter will be sent to the customer, and must be paid to ensure the account is not cancelled prior to the process being set up.

I authorize UnitedHealthcare to debit my group's checking or savings account for all monthly charges for coverage.

I ensure sufficient funds are in my group's checking or savings account to cover my premium invoice.

If the necessary funds are not on deposit in the account at the beginning of the month, my group's coverage may be subject to termination under the terms stated in the contract with UnitedHealthcare. Also, my group may be subject to additional fees incurred by UnitedHealthcare subsequent to the termination date as a result of insufficient funds.

I will promptly notify UnitedHealthcare of any change to my group's checking or savings account. If a change occurs it is my responsibility to provide UnitedHealthcare with the current information.

AUTHORIZATION

I hereby authorize UnitedHealthcare to initiate debits (payments) to the financial institution indicated below for the purpose of paying my group's monthly bill. This financial institution is authorized to debit my account. This authority is to remain in full force and effect until either my group revokes it by giving 30 days prior written notice to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above, or upon termination of my group's coverage with UnitedHealthcare. I have also read and, on behalf of my group, agree to the terms and conditions outlined above.

Authorized Signature

Date

Employer Name/Customer Name/Policy Name

Employer Email Address

Customer Number and Bill Group(s)

Name of Your Financial Institution and Location State

Phone Number of Financial Institution

Transit / American Bankers Association #

Number can be found in lower left corner of your check

Account Number to Debit

Debits to your account will be made on the beginning of each month

■ Yes, I am interested in signing up for Employer eServices. (Please complete information below)

- I am unable to sign up for Employer eServices. (Please complete name and address section)
- I don't have a computer or Internet access.
- I use a third party vendor.
- My hardware/software is not compatible.
- Other _____

Your Name: _____

Phone Number: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Group Number: _____ (this number may be found on your company's UnitedHealthcare member ID card)

Hardware/Software Requirements

Processor – High-speed processor (equivalent of Pentium P266 or greater recommended)

Memory – 64MB or greater (128 MB recommended)

OS – Windows 95, NT or greater

Browser – Internet Explorer 5 or greater, or Netscape Communicator 4.51 - 4.77

List the Employer eServices Users

Please insert an "X" for access needed for each user

Users First & Last Name (List Main User/Primary Contact First)	Phone Number (include area code)	E-Mail Address	Eligibility Inquiry and Update	Online Billing
1)			X	□
2)			X	□
3)			X	□
4)			X	□
5)			X	□

- Check here if interested in Online Bill Payment

Attention: if you check Online Billing, you will no longer receive paper bills. Simply print the invoice from your computer and mail it in.

Please submit to your UnitedHealthcare representative:

Name: _____

Fax: _____

