United Healthcare Level Funded

2-50 CASE SUBMISSION CHECKLIST

- ☐ **Employer application / Payment Authorization Form** ** **/ Specialty Employer Application if any specialty coverages sold – dental, vision, Life/AD&D.** ***Please note, the company name on all employer forms must match exactly (including punctuation) the company's legal name on the wage & tax report. This includes on a signature line.***
- ☐ **Excess Loss Application** **
- ☐ **Alternate Funding Billing & Collection Agreement** ** ***Please be sure to include the "Designated Service Provider" (to whom the service fee is payable – producer or agency), and the Service Provider Representative (producer) on page 5.***
- ☐ **State of NY Public Goods Pool – Forms 4264 & 4399 to Participate, OR Form 4403 if moving from a self-funded carrier, *OR* Non-Participation Election Form** **

****PLEASE NOTE, TYPED SIGNATURES ARE NOT ACCEPTABLE.**

- ☐ **HSA Employer Notification Form – if the employer is electing to use Optum Bank for HSA Accounts**
- ☐ **Copy of Sold Rates**
- ☐ **Copy of employer's most recent Texas Workforce Commission Report** - Each employee needs to be noted as full time, part time, terminated, temporary or seasonal. Payroll reports are not accepted, except for new companies, and those groups moving from a PEO. If there are employees in other states, please submit reports from those states as well. If owners do not appear on the report, the most recent tax filing year's K-1 or Schedule C is required. If K-1s, must prove 100% of ownership. ***Please note – owner only groups are not eligible for UHC Level Funded. There must be at least one W2 employee enrolled.***
- ☐ **If group electing a dental plan with waiting periods for Major Services, submit:** prior carrier current billing; and billing from 12 months ago **OR** renewal. The waiver of the waiting period is only available at time of issue.
- ☐ **First month's premium check (made payable to UnitedHealthcare Services) OR** Employer may elect to use EFT for initial premium check and/or ongoing monthly premium payments. ***If group is submitting a check, please scan a copy to us, then hold original check until after issue, and mail with the completed Binder Check Detail form included in this package to the address indicated. Please send with a delivery confirmation option, and retain that information in the event the check needs to be tracked.***
- ☐ **Employee Applications** ** - for all full time applying for coverage. Minimum information required for waivers on page one: complete Name, SSN, date of hire and hours worked weekly. **OR**, for groups underwritten via HB2015/claims reports ***ONLY*** the enrollment spreadsheet can be submitted in lieu of applications. Waivers should be included with Name and DOH. ***Changes to final enrollment for groups underwritten via applications, must be made on the application form, resigned and redated.***
  ****PLEASE NOTE, TYPED SIGNATURES ARE NOT ACCEPTABLE.**
- ☐ **1099 Common Law Employee & Fact Attestation Form** (If 1099s are considered an eligible class and are being offered benefits). Also provide the contract or written agreement between the employer and each contractor, and payment documentation (most recent 12 weeks of payments) as proof of employment by owner/employer for each 1099 Independent Contractor considered eligible, whether enrolling or waiving. Max no. of 1099s allowed is 25% of total enrolling.
- ☐ **Common Ownership Form** – if there is common ownership with other entities.
- ☐ **Lubbock Chamber of Commerce Attestation Form** – for *all* groups that are in the 34-county area, they must be a member of the Lubbock Chamber of Commerce. Membership will be verified monthly. The counties are: Bailey, Lamb, Hale, Floyd, Motley, Cottle, Foard, Wilbarger, Cochran, Hockley, Lubbock, Crosby, Dickens, King, Knox, Baylor, Yoakum, Terry, Lynn, Garza, Kent, Stonewall, Haskell, Throckmorton, Gaines, Dawson, Borden, Scurry, Fisher, Andrews, Martin, Howard, Mitchell, and Nolan.
- ☐ **Rate Guarantee Form** – for effective dates of August through April, a 15 month rate guarantee is available at no charge. For these effective dates, must complete either the 12 month or the 15 month rate guarantee form.

The Insurance Exchange

15660 Dallas Parkway, Suite 500, LB 60

Dallas, Texas 75248

972-991-6500

UnitedHealthcare Level Funded – Plan Sponsor Application

Have you:

- Signed all forms necessary for health plan application?
- Answered all applicable questions?
- Selected a method of payment?
- Enclosed a check for the initial payment?
- Enclosed a voided check if you selected Electronic Funds Transfer?

Please send correspondence to:
P.O. Box 31394
Salt Lake City, UT 84131
1-877-797-8816

Plan Sponsor Data

Plan Sponsor Tax ID No.			
Full Legal Business Name			
Street Address	City	State	ZIP Code
Mailing Address (if different)	City	State	ZIP Code
Phone No.	Fax No.	County	
Nature of Business	SIC	Date Business Started	
Administrative Contact Person	Executive Contact Person		
Contact Person email			
Third-Party Administrator **United HealthCare Services Inc.**	Legal Name of the Plan		

☐ Yes ☐ No Is your company (you) subject to COBRA? (Your company is subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full- or part-time employees on at least 50% of the typical business days during the previous calendar year. You must include employees residing outside of the United States. Church plans and federal, state and local government plans are excluded from COBRA.) Give the names of persons currently under COBRA, state continuation plan or within their election period:

Employee/Dependent Name	Termination Date of Employment or Qualifying Event	Employee/Dependent Name	Termination Date of Employment or Qualifying Event

☐ Yes ☐ No Has your company ever had a group insurance application denied by an insurer? If yes, give name of insurer, date and reason:

☐ Yes ☐ No Is current group medical coverage being replaced?

List the name, address and phone number of your company's present medical carrier or Third-Party Administrator (TPA)

Carrier Name			
Carrier Address	City	State	ZIP Code
Carrier Phone No.	Effective Date	Termination Date	

☐ Yes ☐ No Has your medical plan been previously underwritten or administered by UnitedHealthcare Insurance Company or any of its affiliates in the last 3 years?

Indicate the Plan Sponsor contribution amounts
(minimum contribution 50% of plan participant only premium):
What percentage of the costs will you pay for plan participants? _____%

For dependents (spouse and children)? _____%

Indicate the Plan Sponsor Default Plan:
Which default plan did you choose for your business? (Include the letter and number of the plan code) _____

Additional Plans Elected: (If applicable) _____

What class of plan participants do you want to exclude from this plan? (Check all that apply.)
☐ None ☐ Union ☐ Non-Union ☐ Hourly ☐ Salary ☐ Non-management ☐ Management

Medical Benefit Plan Option (where available)
☐ Calendar Year ☐ Plan Year

Domestic Partner Coverage ☐ Yes ☐ No

continued

United Healthcare

Plan Sponsor/Plan Participant

How many plan participants does your company currently have on the payroll? _____

Plan participants working a minimum of 30 hours per week (not part time, temporary or substitute) are Eligible Plan Participants:

Number of Eligible Plan Participants _____

Number of Eligible Plan Participants Waiving Coverage _____

Number of Enrolling Plan Participants _____

Prior calendar year average total number of plan participants _____

Under Health Care Reform law, the number of plan participants means the average number of plan participants employed by the company during the preceding calendar year. An plan participant is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly plan participant totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of plan participants at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior-year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Waiting Period Waived for Initial Enrollees ☐ Yes ☐ No

Plan Participant Effective Date

- ☐ Immediate after date of hire
- ☐ Immediate after 30 days
- ☐ Immediate after 60 days
- ☐ Immediate after 90 days
- ☐ First of month after date of hire
- ☐ First of month after 30 days
- ☐ First of month after 60 days

Plan Participant Termination Date: ☐ End of month

Leave of Absence (LOA) Policy

If the plan participant is on an plan sponsor approved leave of absence and the plan sponsor continues to pay required payments, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e., temporarily laid-off) and (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by federal rules such as COBRA.

If the plan participant's medical coverage terminates under this LOA policy, the plan participant may exercise the rights under any applicable continuation of coverage under federal law (COBRA) as described in the Summary Plan Description.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

☐ Yes, we continue medical coverage during an approved leave of absence for plan participants.
☐ No, we do not offer medical coverage during a leave of absence.

☐ Yes ☐ No Does your current health insurer extend coverage for disabilities after termination date? (If yes, provide copy of policy and/or plan participant certificate.)

Consumer Driven Health Plan Options

Health Savings Account (if selected): Which bank will be used: ☐ OptumBank ☐ Other

Eligibility for Medical Coverage

☐ 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. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law, it is the Group's responsibility to accurately determine its Medicare status.

☐ Yes ☐ No Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO) or Administrative Services Organization (ASO)?

☐ Yes ☐ No Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?

If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees who are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

☐ Yes ☐ No Does your group sponsor a plan that covers employees of more than one plan sponsor?

If you answered Yes, then indicate which of the following most closely describes your plan:

- ☐ Professional Employer Organization (PEO)
- ☐ Multiple Employer Welfare Arrangement (MEWA)
- ☐ Taft Hartley Union
- ☐ Governmental
- ☐ Church
- ☐ Employer Association

☐ Yes ☐ No Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Effective Date

Enrollment forms may be submitted with a requested effective date. The effective date will be determined by the Third-Party Administrator in accordance with the provisions of the Summary Plan Description. Do not cancel your current coverage. Coverage is not in effect until you receive written confirmation from the Third-Party Administrator.

Requested Effective Date:_____.

continued

Payment: Cash with Application/Applicable Fees

The group's first month payment plus all applicable fees must be submitted by check with this form or by EFT (Electronic Funds Transfer). All future payments must be paid with a plan sponsor's check or automatically withdrawn through the plan sponsors bank account. Checks must be made out to United HealthCare Services, Inc.

A $25 fee will apply for each future payment made by Direct Bill (does not apply to the first month's payment submitted with the application). The billing fee covers the cost of monthly processing of each account. Nonpayment of this fee will result in termination of the Administrative Services Agreement and Excess Loss Insurance coverage. Payments made by Electronic Funds Transfer do not have a billing fee.

Total Payment Deposit: $_____ A service fee will be applied to non-sufficient funds.

Plan Sponsor Agreement

The agent has explained the details of the coverage and I, the undersigned, acknowledge reading the entire application. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Applicant and United HealthCare Services, Inc. only when the Application receives written approval from United HealthCare Services, Inc.

All enrollees requesting or changing coverage must submit complete medical history. Approval of such changes is subject to United HealthCare Services, Inc. underwriting guidelines. All late enrollees will be declined or excluded for a period of time. Late enrollees are those whose enrollment form is received more than 31 days following their initial eligibility date.

Important Information
UnitedHealthcare reserves the right to review the applicant's payroll/wage and tax records at any time to confirm eligibility. UnitedHealthcare may request the applicant's most recent wage and tax payroll records. The applicant agrees to furnish UnitedHealthcare with all information and documentation which may be reasonably required with regard to eligibility for coverage.

I understand that the information provided on this application and on the Plan Participant Enrollment Application Form is used to make decisions regarding eligibility and pricing. I also understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake) by the Plan Sponsor, agent of the Plan Sponsor, Plan Participant covered under the Plan, could materially affect the underwriting, premium, rating or terms and conditions of the Plan Sponsor's Excess Loss Coverage. In addition, such misrepresentation, concealment, omission of fact or a mistake of fact (whether or not a mutual mistake) could result in increased premium rates, attachment points and/or otherwise change the terms and conditions of the Plan Sponsor's Excess Loss Insurance Policy retroactive to the effective date or as of any premium due date thereafter or termination of that Policy as of the next premium due date. I also understand that the Excess Loss Insurance Policy may be declared null and void in its inception if the Plan Sponsor, any agent of the Plan Sponsor, or Plan Participant covered under the Plan has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of the Excess Loss Insurance Policy.

I further certify that Plan Sponsor is a plan sponsor eligible to sponsor a group health plan under federal law known as ERISA. I also certify that the individuals covered under the Plan Sponsor's group health plan are common law plan participants. United HealthCare Services, Inc. or its affiliates reserves the right to terminate the parties' agreement in the event that information shows that the Plan Sponsor is not eligible to sponsor a group health plan.

Coverage is not in effect until the undersigned receives written approval from United HealthCare Services, Inc. Final approval or disapproval is not taken on the Application until all required information in the Application and all required information for enrolling plan participants and their dependents is submitted and reviewed. No person other than an officer of United HealthCare Services, Inc. has the authority to bind or alter coverage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to the Plan Sponsor if coverage is declined.

United HealthCare Services, Inc. reserves the right to contact any plan participant at the place of business to complete the enrollment process. Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be guilty of insurance fraud, which is a crime, and may be subject to fines and confinement in prison.

Important Notice for Government Contractors: The UnitedHealthcare Level Funded product is not available to any government contractor which is prohibited by contract, regulation or otherwise from receiving a refund or credit of any surplus or money (including the refund or credit of surplus under the Level Funded product) that was allocated under their government contract to pay for plan participant benefits. If you have any questions about whether you are subject to such a prohibition, please consult with your legal counsel, as United HealthCare Services, Inc. is not able to provide you with legal advice on such matters. By completing and signing this application, you are representing to United HealthCare Services, Inc. that you are not prohibited by government contract, regulation or otherwise from receiving a refund or credit of any surplus or money under the Level Funded product.

Unless all pages are attached and completed, this will not be considered as a complete Application.

Dated at (City and State) _____ Dated on (Month, Day and Year) _____

Legal Business Name _____

Signature X_____(Must be signed by a person authorized to purchase coverage for the Plan Sponsor.)

Print Name and Title _____

General Agent Information

General Agent Dallas Insurance Exchange Telephone No. 972-991-6500 NPN# 1304290

Street Address 15660 Dallas Parkway, Suite 500 City Dallas State TX ZIP Code 75248

Producer Information

I hereby certify that all information contained in this form has been explained to the Plan Sponsor and that the answers are correct to the best of my knowledge. I am not aware of anything unfavorable about the Plan Sponsor or any person proposed for coverage except as noted herein. I have complied with the underwriting rules and regulations of the Third-Party Administrator and have explained to the Plan Sponsor the coverages, limitations and exclusions, and other details of the coverage applied for.

I have notified the Plan Sponsor not to terminate present coverage until notified in writing by United HealthCare Services, Inc. of acceptance of this Application.

Producer Name _____

Address _____

Telephone No. _____ Fax No. _____

Social Security/Identification No._____

Producer Signature X_____ Date _____

continued

Case Submission

Please submit the following forms for application of coverage:

☐ Plan Sponsor Application form
☐ Plan Participant Enrollment forms
☐ Payment Authorization form
☐ First month's payment
☐ A copy of the quoted rates
☐ Excess Loss Insurance Application
☐ Most recent copy of Wage and Tax Report

OFFICE USE ONLY

Group Effective Date _____ Approved By _____ Date _____

Comments _____

UnitedHealthcare Level Funded Payment Authorization Form

Send initial check to:
United HealthCare Services, Inc.
P.O. Box 959782
St. Louis, MO 63195-9782
(If overnighting the check, please use UHS Billing,
Attn: Lockbox 959782, 1005 Convention Plaza, St. Louis, MO 63101)

A. APPLICANT INFORMATION

Plan Sponsor Name _____

B. INITIAL METHOD OF PAYMENT

☐ Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)

☐ Check Enclosed

C. ONGOING METHOD OF PAYMENT

☐ Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)

☐ Direct Bill – Monthly (Fees may apply)

D. STATEMENT OF UNDERSTANDING

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

It may take up to 1 month to establish this process.

I authorize United HealthCare Services, Inc. to debit my business checking or savings account for the monthly payment for Administrative Services, Excess Loss Insurance, and claim funding. I will ensure sufficient funds are in my business checking or savings account to cover my monthly payment. If the necessary funds are not on deposit in the account at the beginning of the month, my Administrative Services Agreement with United HealthCare Services, Inc. and Excess Loss Insurance policy with UnitedHealthcare Insurance Company may be subject to termination under the terms stated in the contracts. Also, I understand my business may be subject to additional service fees incurred by United HealthCare Services, Inc. subsequent to the termination date as a result of insufficient funds.

I will promptly notify United HealthCare Services, Inc. of any change to my business checking or savings account. If a change occurs, it is my responsibility to provide United HealthCare Services, Inc. with the current information.

E. ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Type of Account: ☐ Checking ☐ Savings

Account Holder's Name _____ Financial Institution _____
(As it appears on financial institution records.)

Routing/Transit Number (9 digits required) _____ Account Number _____

I (we) hereby authorize United HealthCare Services, Inc. to initiate debit entries to the account and the financial institution named above. In submitting this payment authorization with the application, I understand that the initial payment may be adjusted based on the applicant's medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. United HealthCare Services, Inc. will not be held responsible for a contract lapse or termination due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid. United HealthCare Services, Inc. is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until United HealthCare Services, Inc. has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days' advance notice to terminate or change this authorization. If the automatic bank draft or direct payment by check transaction is returned for any reason, a $25 nonrefundable service fee will be applied.

Authorized or Account Holder Signature X_____ Date _____

Plan Sponsor's Email Address _____

B2B EI20305554.4 10/22 22-1865099

United Healthcare

UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare

Level Funded

Customer/Group name: _____

Group # _____

Effective Date _____

Check # _____

Check Amount _____

Retain a copy of the check for your files and mail with delivery confirmation

Please mail to the following address:

UnitedHealthCare Services, Inc.
P.O. Box 19032
Green Bay, WI 54307-9032

(If overnighting, please mail to:
United Healthcare Services, Inc.
Attn: Lockbox 88106
4900 W. 95th St.
Oak Lawn, IL 60453)

Note: Please do not staple or paper clip this form to the binder check prior to sending to the lockbox. ALWAYS KEEP A COPY FOR YOUR FILES! Thank you!

Level Funded Application for Excess Loss Insurance

A Stock Company: P.O. Box 31394, Salt Lake City, UT 84131-0373 • 1-877-797-8812

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by UnitedHealthcare Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant:		
Address (street, city, state and ZIP):		
Key Contact:	Telephone:	Tax ID:
Applicant is a ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ Proprietorship ☐ Other: _____		
Nature of Business of the Group to be Insured:		Requested Effective Date:
Total Number of Eligible Persons:	Total Number of Plan Participants:	Are Retirees Covered? ☒ No
Affiliates or Subsidiaries: _____ _____	Addresses of Affiliates or Subsidiaries: _____ _____	

Full Name of Administrator: United HealthCare Services, Inc.
Address: P.O. Box 31394, Salt Lake City, UT 84131-0373
Key Contact: Susan Steele
Telephone: 1-877-797-8812

Agent or Broker:
Tax ID/NPN No.:
Address:

continued

United Healthcare

SPECIFIC EXCESS LOSS INSURANCE: ☑ Yes

Incurred Benefit Period: From _____ through _____

Paid Benefit Period: From _____ through _____

Specific Deductible per Covered Person: ☐ $15,000 ☐ $25,000 ☐ $35,000 ☐ $45,000 ☐ other (51+ only) _____
Specific Percentage Reimbursable: 100%
Maximum Specific Benefit per Covered Person: Unlimited
Covered Expenses Under Specific Excess Loss: Medical, Stand-Alone Prescription Drug Program

AGGREGATE EXCESS LOSS INSURANCE: ☑ Yes

Incurred Benefit Period: From _____ through _____

Paid Benefit Period: From _____ through _____

Covered Expenses under Aggregate Excess Loss Coverage: Medical, Stand-Alone Prescription Drug Program
Aggregate Percentage Reimbursable: 100%
Maximum Aggregate Benefit: Unlimited
Minimum Annual Aggregate Deductible: N/A
Runout Deductible: 125%, multiplied by the incurred but unreported Covered Expenses, determined as of the first day of the 4th month immediately following the last day of the Incurred Benefit Period.
Aggregate Accommodation Endorsement included.

It is understood and agreed by the undersigned that:

a. The statements, declarations, and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Plan Sponsor should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.

b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 30 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 30 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.

c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.

d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.

e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____ Title: _____

Date: _____

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____

continued

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Alabama, Arkansas, Louisiana, New Mexico, and Rhode Island:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine and Tennessee:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in Oklahoma:
A WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in Virginia:
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

United Healthcare

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4264 INSTRUCTIONS

All electing payors/third party administrators (TPA)/administrative services only (ASO) organizations and designated providers are required to file Public Goods Pool reports electronically. This also applies to the 1% Statewide Assessment report filed by hospitals. To file electronically, you must establish an electronic filing account and be assigned a secure password. A website has been established at www.hcrapools.org to facilitate this process.

While electronic filing is designed to be user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 671-3800 or via e-mail at webpools@hcrapools.org.

Upon receipt of a fully completed Electronic Filing User ID Application (DOH-4264), the Office of Pool Administration will assign a secure electronic filing user ID and password to your organization, which you will receive via return mail.

New Request/Revision to Existing Account: Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

Payor/TPA/ASO/Provider Name: Enter name of entity that may use the OPA website.

Federal Employer Identification Number (FEIN): Enter FEIN assigned to the entity named above.

Operating Certificate #: (For providers only): Enter Operating Certificate number assigned by the Department of Health to the entity named above.

Report(s) being filed electronically (check ALL applicable types): Check all applicable types of reports that your entity will be filing electronically – Public Goods Pool and/or Statewide Assessment.

Signature: Must be signed by the Chief Executive/Financial Officer and/or Administrator of the entity named above.

Name/Title/Phone Number (Please Print): Enter name, title and phone number of the person signing above.

Address/City/State/Zip Code: Enter address of the person signing above.

E-mail Address: Enter e-mail address of the person signing above. This email address will be used to communicate Health Care Reform Act information, including delinquency reporting notifications and periodic legislative updates.

Date: Enter date this form is signed.

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Finance and Rate Setting

Electronic Filing User ID Application

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

□ **New Request** □ **Revision to Existing Account**

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:

_____

Federal Employer Identification # (FEIN):_____

Operating Certificate # (FOR PROVIDERS ONLY): _____

Report(s) being filed electronically (check ALL that apply):

- □ Public Goods Pool
- □ 1% Statewide Assessment **(for hospitals only)**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. If an email address is provided, this information will be sent electronically to the email address listed. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-mail Address _____

Date _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4399 INSTRUCTIONS

A payor voluntarily electing to make public goods payments directly to the Office of Pool Administration must complete forms DOH-4399 (Payor Election Application) and DOH-4264 (Electronic Filing User ID Application).

Instructions for pages 1 and 2:

Effective Date: Enter effective date of election. Note: An election application received from any payor or organization shall begin on the first day of the month following the date it was received by the Office of Pool Administration unless a future date is specified.

Federal Employer Identification # (FEIN): Enter federal employer identification number (FEIN) of the payor. Please note that Section 2807-j(5)(a)(iii)(D) of the Public Health Law requires the New York State Department of Health to publish the FEIN of all electing payors on a secure website.

Payor Name: Enter name of payor. The payor name is that of the incorporated entity, local government, self-insured fund.

D/B/As: Enter any assumed name(s) ("d/b/a") under which the entity is doing business.

Address: Enter address of payor.

Contact Person: Enter name of contact person that will be responsible for providing the Department with the information regarding the payor's election, lines of business and claims processing.

Phone #: Enter phone number of the contact person.

E-Mail Address: Enter the e-mail address of the contact person.

If the election submission is for a payor that is utilizing a third-party administrator (TPA)/administrative services only (ASO) for claims processing, the following information must also be provided. If more than one TPA/ASO is utilized, attach a list of additional TPAs/ASOs.

TPA/ASO Name: Enter name of the TPA/ASO representing said payor.

TPA/ASO FEIN: Enter FEIN of the TPA/ASO.

The Signature of the chief financial officer or other duly authorized individual binds the payor to make direct pool payments for all its public goods funding obligations, file reports and remit funds in conformance with the Health Care Reform Act (HCRA) provisions and Department requirements, and represents an agreement as to the jurisdiction of the State for purposes of enforcing payments required under Public Health Law sections 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Instructions for page 3:

This form must be completed by all payors making an election and represents a payor's attestation of the coverage it provides. A payor electing to pay the Department's Office of Pool Administration directly is making an election for all its coverages for which it assumes risk for the payment of medical claims. Payors utilizing multiple third-party administrators (TPA)/administrative services only (ASO) organizations must complete a Coverage Information form for each TPA/ASO.

- In each payor category which applies, the payor should mark an "X" in each column to indicate that the payor provides such coverage. Each box marked with an "X" represents the coverages that it assumes risk for. As stated before, a payor is required to elect for all coverages for which it assumes risk for the payment of medical claims. Shaded areas should not be checked.

- If an Article 43 NYS Insurance Law corporation or licensed commercial insurer has a separate incorporation for its Article 44 NYS Public Health Law business, that corporation must check the appropriate boxes on a single election form. Otherwise, the Article 44 NYS Public Health Law business is considered to be a product line of the Article 43 or commercial payor and the payor is required to make a single election for this and all other types of coverage provided by the corporation. A payor, who does not fall into any of the categories listed, should check "Other" in the payor identification section and explain their payor type in the space provided.

Please mail completed election application (DOH-4399 and DOH-4264) to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: _____

FEDERAL EMPLOYER IDENTIFICATION # (FEIN): _____

PAYOR NAME: _____

D/B/As (IF APPLICABLE): _____

ADDRESS: _____

_____

CONTACT PERSON: _____

PHONE #: _____

E-MAIL ADDRESS: _____

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

TPA/ASO NAME: United HealthCare Services, Inc.

TPA/ASO FEIN: 41-1289245

By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory[1], or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

[1]For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature_____ **Title**_____
Chief Financial Officer or Duly Authorized Individual

Date_____

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Payor Election Application

COVERAGE INFORMATION (See Attached For Further Explanation)

PAYOR NAME:_____ **FEDERAL ID#:**_____

TPA/ASO NAME: United HealthCare Services, Inc. **TPA/ASO FEDERAL ID#:** 41-1289245

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

	TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
		INDEMNITY COVERAGE	HMO NON-MEDICAID OR NON-NYS MEDICAID COVERAGE	SELF-INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOVT PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOVT CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION LAW COVERAGE	NEW YORK STATE MOTOR VEHICLE REPARATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTERS' BENEFIT LAW COVERAGE	OTHER COVERAGE
1	Corporations Organized & Operating in accordance with Article 43 of the NYS Insurance Law										
2	Corporations that are Commercial Insurers licensed in New York State										
3	Corporations Organized & Operating in accordance with Article 44 of the NYS Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the NYS Insurance Law										
4	Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
5	Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
6	New York State Governmental Agency/ New York State Local Government										
7	Other (please explain below): Includes: State/Local Governments outside New York for Medical Assistance Programs; insurers licensed outside New York State, authorized to write OTHER than Accident and Health										
8	HMOs and insurers licensed outside New York State, authorized to write Accident and Health										

Explanation of "Other" Payor Identification

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
COVERAGE INFORMATION

Payor Type 1: Corporation organized and operating in accordance with Article 43 of the New York State Insurance Law offering:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

Payor Type 2: Commercial Insurance Corporation licensed by New York State offering:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid insureds

→ New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Volunteer Ambulance Workers Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Volunteer Firefighters Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

Payor Type 3: Corporation organized and operating in accordance with Article 44 of the New York State Public Health Law not incorporated as a NYS licensed commercial insurer or under Article 43 of the New York State Insurance Law offering:

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid managed care enrollees

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

Payor Type 4/5: Self insured fund offering:

→ self insured employee health coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services and regional GME covered lives assessments for NYS resident plan participants

→ self insured employee health coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured **non-New York State** Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

→ self insured New York State Motor Vehicles Reparation Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured **non-New York State** Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

Payor Type 6: New York State Governmental Agency/ New York State Local Government:

→ New York State political subdivision for New York State county corrections, New York City corrections, and, New York State governmental agencies for New York State administered payments that reimburse hospitals for rendered inpatient services to eligible patients. (e.g. Office of Mental Health payments for services provided to individuals residing in New York State operated developmental centers), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

Payor Type 7: Other

→ Insurers **licensed outside New York State, authorized to write OTHER than Accident and Health** thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ States **other than New York State** and localities **other than New York State political subdivisions** for medical assistance program expenses (i.e. Medicaid Programs in states OTHER than New York State), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

→ NYS licensed fraternal benefit societies offering coverage with or without an expense incurred inpatient hospital component, requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

Payor Type 8: HMOs and insurers licensed outside New York State, authorized to write Accident and Health:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMOs **organized and operating outside New York State Insurance and Public Health Laws**, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4403 INSTRUCTIONS

This form is to be completed by a payor whose status has changed from the original election as it relates to whether a TPA/ASO is utilized for claims processing.

Effective Date: Enter effective date of status change.

Payor Information: Enter payor name, federal identification number (FEIN), contact person, and phone #.

Type of Status Change: If you are adding or changing a TPA/ASO organization, check appropriate box on type of status change being submitted.

Previous TPA/ASO Information: Enter previous TPA/ASO name/FEIN, if applicable.

New or Additional TPA/ASO Information: Enter new or additional TPA/ASO name, FEIN, address, contact person, and phone number.

Check one of the following: Check appropriate box regarding claims run out, if applicable.

Signature Section: An authorized individual from the electing payor's company must sign and date the form.

ALS

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Finance and Rate Setting

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

This form must be completed if an electing payor is adding or changing their TPA/ASO.

Effective Date:_____

PAYOR INFORMATION:

Payor Name: _____ Payor FEIN: _____

Contact Person: _____ Phone #: _____

Type of Status Change (check appropriate box):

☐ **Additional TPA/ASO** (complete Section II only)

☐ **Changing TPA/ASO** (complete Sections I, II & III)

I. PREVIOUS TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

II. NEW or ADDITIONAL TPA/ASO INFORMATION:

TPA/ASO Name: United HealthCare Services, Inc. TPA/ASO FEIN: 41-1289245

Address: PO Box 31373

Salt Lake City, UT 84131-0373

TPA/ASO Contact Person: Policy Administration TPA/ASO Phone #: 800-291-2634

III. CHECK ONE OF THE FOLLOWING:

☐ Previous TPA/ASO will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.

☐ All self-insured claims that previous TPA/ASO was responsible for have been adjudicated effective_____.

☐ New TPA/ASO is assuming responsibility for all pending claims and HCRA reporting requirements.

Signature of Payor: _____ **Date:** _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

All Savers® Alternate Funding

Non-Participation Election Form—New York Public Goods Pool.

What is the Pool?
The New York Public Goods Pool is a fund created by the state of New York to finance health care initiatives and care for the indigent within that state. The Pool was started in 1997 and is funded by a surcharge tax on all health services rendered in the state of New York. All health insurance plans, insured and self-funded, are required by law to pay the tax. This state law is not preempted by ERISA for a self-funded plan.

Effect of NOT electing into the Pool.
Self-funded plans pay higher surcharge rates if non-participating, which are then included in a provider's claim reimbursement. The surcharge for a non-participating self-funded customer can be in excess of 60 percent of the cost of the claim. In addition, any self-funded customer not electing into the Pool shall incur a monthly administrative fee of $1.25 per employee, which will be charged on your monthly billing.

Effect of electing into the Pool.
Self-funded plans that elect to pay the Pool directly are promising to pay the state a surcharge tax made up of two components. The first is a covered lives fee based on the number of covered employees residing in the state of New York. This part of the tax varies by the region of New York that the employee resides in and whether they have single or family coverage. If there are no employees residing in New York, then no tax is due from this portion of the surcharge tax. The second component is a surcharge tax on the dollar value of claims incurred in the state of New York.

Company Name and Group Number _____
elects **not to participate** in the New York Public Goods Pool and further acknowledges and agrees that a monthly administrative fee of $1.25 per employee will be charged on your monthly bill due to non-participation.

_____ _____
Signature **Printed Name**
Authorized Representative of Customer **Authorized Representative of Customer**

_____
Date

Completion of this form does not negate any prior election into the Pool.

To rescind election in the Pool, Form 4404 would need to be completed and filed with the state of New York. Form 4404 is available at **heath.ny.gov/forms/doh-4404.pdf.**

Return this signed Non-Participation Election form to:

uhoadminallsavers@uhc.com

Fax: 920-661-9959

Policy Administration
UnitedHealthcare Services Inc.
P.O. Box 31373
Salt Lake City, UT 84131-0373

MT-1166754.2 7/18 ©2018 United HealthCare Services, Inc. 18-8703-B

UnitedHealthcare®

Level Funded Billing and Collection Agreement

This Billing and Collection Agreement ("Agreement") by and among United HealthCare Services, Inc., and its subsidiaries and affiliates (collectively "UHS"), the designated service provider(s) (individually and collectively, "Service Provider") indicated on the attached Exhibit 1 to this Agreement ("Exhibit 1"), and [enter CUSTOMER NAME below] ("Customer"), sets forth the terms and conditions under which UHS will assist in the billing and collection of Service Fees from Customer, and the processing and remittance of the Service Fees to Service Provider. This Agreement is effective as of [enter EFFECTIVE DATE below] ("Effective Date").

Customer Name

Effective Date

Recitals

WHEREAS, Customer has purchased a stop loss insurance product ("Stop Loss Plan") and administrative services from a company controlled by or under common control with UHS including, without limitation, UnitedHealthcare Insurance Company (each, an "Affiliate").

WHEREAS, Customer and Service Provider represent that they have entered into one or more valid agreements under which Service Provider agrees to provide services to assist Customer with its benefit plan (individually and collectively, "Service Agreement") in return for agreed upon compensation to be paid by Customer ("Service Fee").

WHEREAS, Customer and Service Provider acknowledge that UHS or affiliated stop loss carriers are not a party to the Service Agreement.

WHEREAS, Customer and Service Provider have requested that UHS bill Customer for the monthly Service Fee on the Service Provider's behalf, and include the Service Fee on the bill for stop loss premium and administrative services for the Customer's administrative ease.

WHEREAS, Customer, Service Provider, and UHS acknowledge and agree that the Service Fee is not part of the premium charged for Stop Loss Plan offered by affiliated stop loss carriers nor is it part of the administrative services provided by UHS.

NOW THEREFORE, UHS agrees to provide the billing services described herein in reliance upon and subject to the aforementioned recitals and terms and conditions set forth below.

Terms and Conditions

Section 1: Rights and Responsibilities

A. Responsibilities of UHS:

1. UHS agrees to bill Customer for the Service Fee identified in Exhibit 1 on a monthly basis and incorporate this Service Fee billing with the stop loss premium and administrative services bill purchased by the Customer during the Term.
2. UHS agrees to forward or transmit any collected Service Fee to the appropriate Service Provider (as outlined in Exhibit 1) within sixty (60) days of receipt of the Service Fee from Customer.
3. UHS agrees that it is responsible for any tax reporting related to the payment of the Service Fee to the Service Provider.

continued

B. Responsibilities of Customer:
   1. Customer agrees to pay the Service Fee at the same time as payment is made for the stop loss premium and administrative services included on the same invoice.
   2. Customer agrees to notify UHS immediately of the termination of any one or more Service Agreement(s).
   3. Customer shall take all steps necessary to recover from Service Provider any overpayment of the Service Fee which is due to Customer's error.

C. Responsibilities of Service Provider:
   1. Service Provider agrees to notify UHS immediately of any change in the contractual relationship between it and the Customer that would impact the Service Fee payment.
   2. Service Provider agrees to return to UHS any Service Fee overpayments that occur as a result of a processing error by UHS within thirty (30) days of UHS's request for such repayment.
   3. Service Provider acknowledges and agrees that it is solely responsible for determining what licenses (state, local or otherwise) are required for it to perform the services described herein and/or in the Service Agreement, and for obtaining such licenses and maintaining them in good standing throughout the Term.

Section 2: Payments and Adjustments

A. All parties agree to promptly notify the others upon becoming aware of an incorrect payment amount, and to promptly remit any amounts overpaid.

B. If the amount the Customer pays to UHS for both Service Fee and premium related to the Administrative Service(s) purchased by Customer is less than the amount billed by UHS, the amount forwarded to the Service Provider will vary in direct proportion to the difference in the amount paid compared to the amount billed. This variation will apply regardless of the basis used for calculating the Service Fee, including a percent of premium, a set amount per enrolled employee, per month, or a set dollar amount per month.

C. UHS may recover overpayments from Service Provider by offsetting the overpayment against any other compensation due to Service Provider by UHS.

D. Service Fees will be subject to garnishments and any other legal attachments as required by a legal court order or similar action. Service Fees also will be subject to any assignment of compensation elections that UHS has on file from the Service Provider.

E. The Service Fee amount may be modified on a prospective basis only. UHS must be informed of the change in writing, including the date that the change is requested to be implemented (which must be at least thirty (30) days from the date of such notice to UHS). UHS has the right to designate a date subsequent to the date requested if, in its reasonable judgment, UHS believes that such a delay is necessary.

Section 3: Amendments

A. UHS may amend the terms and conditions of this Agreement, except for terms and conditions related to the amount of the Service Fee, at any time by notifying Customer and Service Provider of the change in writing at least thirty (30) days prior to the effective date of the change.

B. Customer may request a change to the amount of the Service Fee subject to the requirements contained in Section 2(D) above.

C. All other amendments to the provisions of this Agreement, not addressed by 3(A) or 3(B) above, must be set forth in writing and signed by an authorized representative of each party to this Agreement.

continued

Section 4: Term and Termination

This Agreement is effective on the Effective Date and shall continue until terminated as set forth in this Section 4 (the "Term").

A. Customer may terminate this Agreement at any time, for any reason (or no reason), by providing written notice of such termination; provided, however, that if the termination does not specify a future effective date, Customer acknowledges and agrees that such termination will be effective the first of the month following the Customer's then paid coverage period. Unless otherwise specifically so stated, notice that the Customer has elected to work with a different Service Provider shall be considered to be effective notice of the termination of this Agreement.

B. UHS and Service Provider may terminate this Agreement at any time, for any reason (or no reason), by providing written notice of such termination at least sixty (60) or more days before the effective date of the termination.

C. UHS may terminate this Agreement immediately, upon written notice to Customer and Service Provider, if UHS is made aware that responsibilities and duties called for herein are no longer legally permissible.

D. This Agreement will terminate automatically and without any further action being required on the part of any party as of the effective date of the cancellation or termination of the last of the stop loss or administrative services purchased by Customer from an Affiliate then in existence.

E. In addition, this Agreement will terminate automatically and without any further action being required on the part of any party as of the effective date of a subsequently executed Billing and Collection Agreement by and between UHS, Customer and any service provider (whether the same Service Provider named in Exhibit 1 or not).

F. Notwithstanding the foregoing, the provisions of this Agreement which, by their nature, are intended to survive beyond the termination of this Agreement shall survive such termination, including, but not limited to, Sections 1(B), 1(C), 2(A), 2(C), 2(D), and 5.

Section 5: Additional Customer and Service Provider Acknowledgments and Approvals

A. Customer understands that UHS may compensate Service Provider for the sale, service and retention of Stop Loss Plan and that the Stop Loss Plan purchased by Customer may, if eligible, be taken into account in the calculation of any bonus or override program offered by UHS to Service Provider. Eligibility for such bonus and/or override programs is determined by UHS based on a number of factors including, but not limited to, state-specific regulatory requirements.

B. By executing this Agreement below, Customer represents that either the payment of a bonus and/or override by UHS, as described in 5(A) above, does not create a conflict of interest or, to the extent of any apparent conflict, it is understood and hereby waived by Customer.

C. Customer and Service Provider acknowledge and agree that the Service Fee may be deposited by UHS in an account with other funds collected by UHS in the normal course of business. All available funds may be invested in short-term instruments shortly after deposit into this account (typically once per day) which can earn interest income at market rates.

   With relation to utilization for such short-term investments, Service Fees are generally treated like all other funds collected by UHS in the normal course of business so long as in UHS's possession. Service Fees are in UHS's possession for a period of approximately 30 to 60 days under normal circumstances prior to being forwarded to the Service Provider, as discussed elsewhere in this Agreement. The payer of any interest received by UHS on Service Fees as the result of such short-term investment activity will be the sponsor of the relevant investment vehicle. UHS may keep any interest earned from these Investments to defray the administrative costs associated with, and as consideration for, UHS's services under this Agreement.

D. Service Provider acknowledges that UHS has no obligations to Service Provider to collect amounts owed to it by Customer other than those expressly set forth in this Agreement.

E. This Agreement represents the entire understanding and agreement between the parties with respect to the subject matter addressed herein and entirely and completely supersedes, voids and replaces all agreements, negotiations, understandings and representations (whether written or oral) in existence between the parties as of the Effective Date and relating to the same subject matter.

F. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same Agreement. A signature by facsimile transmission or other electronic means which allows the identity of the signer to be reasonably confirmed shall be as good and binding as an original signature.

continued

Signatures:

Through the signature of their respective authorized representatives, the parties hereby agree to the terms and conditions of this Agreement.

For Customer:

_____

Signature – Authorized Representative of Customer

_____

Printed Name

_____

Title

_____

Date

For Service Provider (Producer):

_____

Signature – Service Provider

_____

Printed Name

_____

Producer ID

_____

Date

For UHS:

_____

Signature – Authorized Representative of UHS

_____

Printed Name

_____

Title

_____

Date

For Service Provider (if more than one):

_____

Signature – Service Provider

_____

Printed Name

_____

Producer ID

_____

Date

continued

BILLING AND COLLECTION AGREEMENT – Exhibit 1

This Section to Be Completed by Customer

Customer Name: _____

Service Agreement Effective Date: _____

Designation of Service Provider(s): Note: If more than two Service Providers are designated, please complete two versions of Exhibit 1 and provide relevant information for additional Service Providers on such additional Exhibits.

Designated Service Provider
(Person or firm that will receive Service Fee):

_____

Service Provider Representative
Responsible for Customer's Account:

_____

Service Provider Address:

_____

_____

Designated Service Provider
(Person or firm that will receive Service Fee):

_____

Service Provider Representative
Responsible for Customer's Account:

_____

Service Provider Address:

_____

_____

PLEASE NOTE THAT THE INFORMATION CONTAINED IN THE BOX ABOVE MAY BE CHANGED PERIODICALLY BY UHS AS DIRECTED. ANY OTHER ALTERATIONS TO THE TOP HALF OF THIS FORM MUST BE INITIALED BY THE CUSTOMER TO DOCUMENT CONSENT TO THE CHANGE.

Please indicate the **TOTAL** Service Fee rate to be paid to the Service Provider(s)

Per Employee Per Month (PEPM) $ _____ .00

IF MORE THAN ONE SERVICE PROVIDER IS LISTED ABOVE, PLEASE INDICATE **WITH SPECIFICITY** HOW THE TOTAL FEE SHOULD BE DIVIDED BETWEEN THE SERVICE PROVIDERS:

_____

☐ **SPECIALTY BENEFITS:** Check here if the Designated Service Provider and Service Provider Representative named above are to be designated as the Agent of Record and Writing Agent, respectively, of all of the Customer's non-medical lines of coverage. Checking this box will replace the existing Agent of Record and Writing Agent for those lines of coverage. If more than one Service Provider is designated above, please indicate with specificity which, if any, non- medical lines of coverage should have changes to the currently designated Agent of Record:

_____

Signature (Authorized Representative of Customer): _____

Name (Printed) _____ **Title** _____ **Phone** _____

United Healthcare

Acknowledgment for 15-month rate guarantee

I acknowledge that I understand and agree with the following arrangements related to our 15-month rate guarantee and the impact to the excess loss policy period we are entering into with All Savers Insurance Company ("ASIC") or affiliated stop loss carriers.

The initial term of the excess loss policy will be a period of 3 months and therefore will fall under the early termination clause of the Administrative Services Agreement Section 6.5, which reads:

If this Agreement or the Stop Loss Policy terminates during the Term of the Agreement or before the end of the third calendar month following the close of the Term of the Agreement, United shall conduct a reconciliation after the 24th calendar month following the close of that Term of the Agreement (the "Reconciliation Date") and also calculate a reserve (the "Customer IBNR Reserve") for claims incurred during the Term of the Agreement but not paid prior to the Reconciliation Date. United will reconcile the amount of the cumulative Maximum Monthly Claim Liability payments paid to United for the Term of the Agreement over (i) the amount of claims incurred during the Term of the Agreement and paid before the Reconciliation Date, less any specific stop loss insurance reimbursements, and (ii) the Customer IBNR Reserve. The Customer IBNR Reserve shall be equal to 100 percent of claim payments made during the 3 months prior to the Reconciliation Date, and in no event shall the Customer IBNR Reserve be less than $0. Any amount in excess of the Customer IBNR shall be payable to United as a Deferred Service Fee in accordance with the applicable provision in Section 5.4.

The Individual Stop Loss and Aggregate Stop Loss coverage with ASIC or affiliated stop loss carriers will be in effect for an initial 3-month term, and will renew for a 12-month term immediately following the initial shortened term. The stop loss limits will reset on the first day of the 12-month term.

By signing below, I confirm and acknowledge full understanding of the above changes to our stop loss policy period resulting from our 15-month rate guarantee.

Legal Business Name:_____

By Authorized Signature: _____

Print Name and Title:_____

Date: _____

By Broker Signature: _____

Print Name: _____

Date: _____

United Healthcare

12-month rate guarantee

By signing below I, on behalf of the employee benefit plan listed below, confirm that I was offered a 15-month rate guarantee on my All Savers Alternate Funding plan year, and I am declining that offer and will be subject to a renewal after a 12-month period.

Legal Business Name:_____

Authorized Signature: _____

Print Name and Title:_____

Date: _____

Broker Signature:_____

Print Name: _____

Date: _____

United Healthcare

OPTUM Bank
Member FDIC

Health Savings Account Employer Notification Form

If the Employer Group elects to promote Optum Bank to administer their Health Savings Accounts (HSAs), this form is to be used during implementation to gather information about their requirements for system set up.

The completed form can be emailed to hsasetup@optumbank.com or Faxed to (800) 765-6766

* Denotes a required field. All required fields must be completed in order to avoid processing delays.

In order to assist with system set up - please complete this form using ALL CAPS.

☐ New Form ☐ Updated Form	Date Submitted:
Medical Policy# / Group ID#: *	Employer Group TIN: *
Medical Carrier / Provider: * UHC "All Savers with Motion" Bis Payer to be used: ALL SAVERS	

1 Employer Information

Employer Name: *			
Employer Address 1: *			
Employer Address 2:			
City: *	State: *	Zip Code: *	
Agency Name:	Agency Tax ID #:		
Agency Address:			
Agency Contact Name:			
Agency Phone #:	Agency Fax # :	Agency E-mail:	
Broker Name:	Broker ID/License #:		
Broker Address:			
Broker Phone #:	Broker Fax # :	Broker E-mail:	

2 Policy Information

Effective Date of High Deductible Health Plan: *	
Estimated Number of HSAs :	HSA Sold Date:

3 Enrollment Method * (must select one of the following as the primary enrollment method)

☐ Employer Portal

☐ Batch

☐ Online

☐ Paper

Enrollment Year: *

4 Will Payroll deductions be deposited into the Employee's HSA? *

☐ Yes ☐ No

5 Will Employer be contributing funds to the Employee's HSA? *

☐ Yes ☐ No

OPTUM Bank
Member FDIC

Health Savings Account Employer Notification Form

6 Contribution Method * (required if YES to sections 4 or 5)

☐ ACH Direct Deposit ☐ Combined Sum ACH/ Wire ☐ Employer Portal

7 Contribution Frequency * (required if YES to sections 4 or 5)

☐ Weekly ☐ Semi-monthly ☐ Monthly ☐ Other

8 Does Employer want to receive a listing of the Employee Account #'s (Account Number File/ANF) via secure email? * (required if YES to sections 4 or 5)

☐ Yes ☐ No

Recipient Name:	
Phone #:	E-mail:
Frequency : ☐ Daily ☐ Semi-weekly ☐ Weekly ☐ Monthly	

9 Contact Information

1. Form Submitter: *	
Phone #: *	E-mail: *
2. Primary Contact (HR Contact):*	
Phone #: *	E-mail: *
3. Enrollment/Eligibility Contact ☐ check if same as Primary Contact (#2)	
Phone #:	E-mail:
4. Reporting Contact**:*** ☐ check if same as Primary Contact (#2)	
Phone #**: ***	E-mail: *
5. Contribution Contact: ☐ check if same as Primary Contact (#2) *** (required if YES to sections 4 or 5)**	
Phone #: *	E-mail:
6. Payroll Vendor/System Contact: ☐ check if same as Primary Contact (#2)	
Phone #:	E-mail:

10 Additional Contacts:

Contact Name:	Contact Type:
Phone #:	E-mail:
Contact Name:	Contact Type:
Phone #:	E-mail:

Notes:

Common Ownership Certification

Please complete, sign and submit the Common Ownership Certification.

Renewing Groups—Please complete and return even if you do not have multiple companies.

Please list all companies that are eligible to be included as part of a consolidated federal tax return (even if they don't file a consolidated federal tax return) or who are part of a controlled group as defined under the Internal Revenue Code.

Plan Sponsor _____

Group Number (if renewal) _____

Primary Business Location _____

Please check one of the following:

◯ I certify that my business applying for coverage with UnitedHealthcare is not part of a controlled group (commonly owned or affiliates) as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. (Single business that has no common ownership/affiliates.)

Or

◯ I certify that my business(es) applying for coverage with UnitedHealthcare (1) is eligible to file a consolidated federal tax return or (2) meets the IRS test for being a controlled group or affiliated service group as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. I further certify there are no other affiliated entities, other than the ones listed below, who are part of the controlled group affiliated service group that includes my business.

Business Name	Federal Tax ID #	# of Eligible*	On This Policy
1. _____	_____	_____	◯ Yes / No ◯
2. _____	_____	_____	◯ Yes / No ◯
3. _____	_____	_____	◯ Yes / No ◯
4. _____	_____	_____	◯ Yes / No ◯
5. _____	_____	_____	◯ Yes / No ◯
6. _____	_____	_____	◯ Yes / No ◯

The undersigned certifies that the foregoing information is true, correct and complete, and fully understands that any false statements or failure to provide all available information may constitute the basis for rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

_____	_____	_____
Name (please print) and Title	Signature	Date

*When listing the number of Eligible, count the number of Eligible plan participants for each business, even if they're not offered this insurance.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

United Healthcare

Common Law Employee and Fact Attestation Form

Your employer sponsored group health insurance policy may only provide coverage to your eligible common law employees and their eligible dependents. **Note: In most instances, individuals who are compensated via an IRS 1099 Form, instead of a W-2, are independent contractors and NOT common law employees eligible for coverage.**

You have requested this form because you believe that the individual(s) listed below are your common law employee(s) and not independent contractor(s) per federal or state law. To confirm, we request:

- Your explanation and attestation why you believe that the individual(s) listed meet federal and state requirements of a common law employee;
- The following documentation to support federal and state requirements must be submitted: A written contract or agreement; most recent 12 weeks of payment records showing hourly/weekly/or salaried with paid vacation and sick days, expense reimbursement, and records of payment of federal and state employee taxes; evidence of pension, other insurance and employee benefits; and an IRS Form SS-8 if applicable.

1. The worker(s) listed below work for my company on a full-time, year-round basis.
2. The relationship between myself, the owner/employer, and the worker(s) is permanent and/or indefinite, where I provide instruction, training and evaluation.
3. I, the employer, invest more money in the worker(s) to perform the service, than the worker(s) does.
4. I, the employer, have the right to control the details of how and when the worker's services are performed.
5. I, the employer, control the business aspects of the worker's job, including but not limited to how the worker(s) are paid, expenses are reimbursed, and I provide the tools and/or supplies.
6. I, the employer, provide other types of employee benefits to the worker(s), such as a pension plan, other insurance such as life or disability, and pay for vacation and overtime pay.
7. I, the employer, agree to contribute the same amount of money toward the premium as I contribute to my similarly situated workers compensated via a W-2.
8. I, the employer, agree to require the same waiting period for the listed worker(s) as for my regular, W-2, employees.
9. I, the employer, agree to extend the coverage offering to all common law employees who meet these qualifications, including those I may hire in the future.
10. I, the employer, pay the required state and federal employee taxes.

Please list below all individuals who meet the above qualifications and for whom your attestation applies.

Name	Social Security number	Date of hire	Hours per week

continued

Owner explanation of why you believe that the individual(s) listed meet federal and state requirements of a common law employee:

_____

_____

_____

I hereby attest that I am familiar with the requirements of what constitutes a common law employee, and the individuals listed above are my common law employees and not independent contractors. I further agree that this document and attestation may be provided to state and federal authorities and any misrepresentation or fraudulent statement provided above may result in termination of coverage or other legal action.

Signature of Owner_____

Date_____ Group #_____

United Healthcare

Lubbock Chamber of Commerce Employer and Broker certification.

Employer and Broker certifies that it meets the requirements listed below to be an employer member of the Lubbock Chamber of Commerce. It understands that it must be a member of the Lubbock Chamber of Commerce in good standing in order to be eligible to apply for any plans endorsed by the Chamber.

Employer and Broker further understand that status as an employer member, by itself, is not a guarantee of coverage and does not confer upon it the right to participate in any plans endorsed by the Chamber, and that employer member will be further subject to any underwriting, enrollment and eligibility requirements for any plans endorsed by the Chamber.

I certify that each of the following requirements has been met:

1. Employer and Broker certifies that it is a member in good standing of the Lubbock Chamber of Commerce.
2. Employer and Broker certifies that the Employer has a principal place of business in the same region that does not exceed the boundaries established by the Lubbock Chamber of Commerce and the administrator.
3. Employer and Broker agrees to notify the administrator in the event any factual information that provided the basis for the Certification has changed.
4. Employer and Broker agrees to provide the administrator with documentation to verify the accuracy of the information being certified upon request.

By signing below, I attest to the accuracy, truthfulness, and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in a loss or termination of coverage, or other consequences as permitted by law, including, but not limited to, rescission of coverage. I also understand that any plans endorsed by the Chamber will be terminated on the policy anniversary date if the Employer is no longer in good standing with the Lubbock Chamber of Commerce.

Employer Member

By: _____

Print Name: _____

Title: _____ Date: _____

Broker Member

By: _____

Print Name: _____

Title: _____ Date: _____

LUBBOCK CHAMBER OF COMMERCE
WORKING FOR BUSINESS. BELIEVING IN LUBBOCK.

UnitedHealthcare®

Level Funded plan participant enrollment application form

UnitedHealthcare Level Funded

Send correspondence to: P.O. Box 31394, Salt Lake City, UT 84131 • Phone: 1-877-797-8812

Fill out the entire enrollment application form to avoid processing delay. Please clearly print all information.

Enrollee Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Group No. ___ ___ ___ ___ ___ ___ ___ ___

Enrollee Information

Plan Sponsor Name

Plan Sponsor Address (If more than one location)

Last Name | First Name | Initial

☐ Single ☐ Married

Address | Apt #

City | State | ZIP | County

Phone # | Email Address

Cell Phone # | Occupation

Date Employed Full Time | Average Hours Worked Per Week | Are you an independent contractor? ☐ Yes ☐ No

continued

United Healthcare

Enrollee and Dependent Information (only for those applying)

If you need to list additional dependents, please use lined paper, sign and date it, and check this box: ☐

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Last Name					
Gender	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Date of Birth					
Height					
Weight					
Tobacco or nicotine use including e-cigarette or similar devices in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Social Security Number					
Primary Care Physician's Name					
Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)					
Currently Working Full Time	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Plan to Keep Other Insurance Coverage	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare/ Medicaid	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Medicare/Medicaid Coverage Effective Date					

Coverage and Change Request Information

Medical: ☐ Plan Participant ☐ Family ☐ Plan Participant/Spouse ☐ Plan Participant/Dependent Child(ren)

Name of Medical Plan You Have Selected: _____

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to School Full Time ☐ Court Order

Date of Event: _____ (you may be required to provide proof of event)

Attach a written and signed statement by the plan sponsor for a requested coverage effective date other than plan participant effective date. Effective date may not be guaranteed.

continued

Medical History

Please answer the following questions for yourself and each person listed on the Enrollee and Dependent Information Section on page 2 of this form. Please answer completely and truthfully. Please note that, if you fraudulently leave out or fraudulently misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your coverage became effective.

All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.

1. In the last 5 years, has anyone on this application been diagnosed with, or been examined/treated by a health care professional for any illness, injury, or health condition in any of the categories listed below?

a.	Cancer/Tumor (indicate type of cancer and location of tumor below)	☐ Yes ☐ No
b.	Mental Health/Substance Abuse	☐ Yes ☐ No
c.	Blood Disorders/Hemophilia	☐ Yes ☐ No
d.	Congenital Disorder/Disability	☐ Yes ☐ No
e.	Heart/High Blood Pressure/Circulatory Disease/Stroke	☐ Yes ☐ No
f.	Kidney/Bladder/Urinary Disorders/ESRD	☐ Yes ☐ No
g.	Transplant – prior, pending or recommended (indicate organ)	☐ Yes ☐ No
h.	Digestive Disorder/Crohns Disease/Ulcerative Colitis	☐ Yes ☐ No
i.	Liver Disease/Cirrhosis/Hepatitis (indicate type below)	☐ Yes ☐ No
j.	Endocrine/Diabetes/Growth Hormone/Thyroid	☐ Yes ☐ No
k.	Immune System/Lupus/Psoriasis/HIV/AIDS	☐ Yes ☐ No
l.	Nervous System Disorder/Multiple Sclerosis/Seizure/Epilepsy/Paralysis	☐ Yes ☐ No
m.	Lung/Respiratory/Cystic Fibrosis/COPD	☐ Yes ☐ No
n.	Back/Bones/Joints/Muscles/Arthritis	☐ Yes ☐ No
o.	Reproductive/Infertility/Breast Disorders/PCOS	☐ Yes ☐ No

If your answer to any of the above categories is "yes" please provide detailed information below for each person involved.

2. Is anyone on this application currently pregnant? If "yes," please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section. ☐ Yes ☐ No

3. In the past 12 months, has anyone on this application been hospitalized (inpatient or outpatient) or had surgery? If your answer is "yes," please provide detailed information below including surgery (if applicable), diagnosis, current and future treatment recommended for each person involved. ☐ Yes ☐ No

4. In the past 12 months, has anyone on this application been recommended or prescribed medications, or is anyone currently taking prescription medications? If your answer is "yes," please provide detailed information below for each person involved. ☐ Yes ☐ No

5. In the past 5 years, has anyone on this application been tested for or diagnosed with, received medical treatment, or had medical treatment recommended, or been hospitalized for any illness, injury or health condition not previously mentioned? If your answer is "yes," please provide detailed information below for each person involved. ☐ Yes ☐ No

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and date and sign that sheet.)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Dates Treated	Prognosis

continued

Prior Medical Coverage Information

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by this plan sponsor's prior group medical plan?

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by any medical plan other than this plan sponsor's prior group plan?

If yes:

Insurance Company Name _____ Phone # _____ Policy/Group #_____

Termination Date _____ Effective Date _____ Reason for Termination _____

Who was covered?_____

Type of Plan: ☐ Prior Plan Sponsor Group Plan ☐ Spouse's Plan Sponsor Group Plan ☐ Individual Policy

☐ Other _____

Signature

I declare that all statements and responses contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 120 days that was provided to UnitedHealthcare, are true and correct and that no material information has been withheld or omitted. I also understand that the information provided on this form is used to make decisions regarding eligibility and pricing. I understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake), could materially affect the underwriting, premium, rating or terms and conditions of my plan sponsor's Excess Loss Insurance Policy ("Policy") which could result in changes to the terms and conditions of my plan sponsor's Excess Loss Insurance Policy, including retroactive increased premium rates and attachment points, or termination of that Policy. I also understand that willful or intentional misrepresentation, concealment or omission of any material fact affecting terms, conditions, or underwriting of my plan sponsor's Excess Loss Insurance Policy could result in that Policy being null and void in its inception.

I understand and I agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Summary Plan Description. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment application form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

All pages must be attached and complete, including this authorization, for the enrollment application form to be considered complete. Incomplete enrollment application forms may be rejected.

I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Authorization to Disclose Medical Information for Enrollment

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, pharmacy benefit managers, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents proposed for coverage to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Enrollee Signature X _____

Date_____

If signed by a representative of enrollee, please indicate the representative's legal authority to act on behalf of enrollee.

_____

continued

Waiver (please complete if you are waiving medical coverage)

I waive medical coverage for: ☐ Self (and dependents) ☐ Spouse ☐ Dependent Children

Please state reason for waiving coverage: _____

Qualifying Coverage: _____ Other: _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X _____ Date _____

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION – The results of any genetic test, including genetic test information, shall not be used as the basis to: (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.

United Healthcare