UnitedHealthcare of Texas, Inc.

1-50 CASE SUBMISSION CHECKLIST

- ☐ **Employer Application**
- ☐ **Product & Benefit Selection Form**
- ☐ **Copy of Sold Rates**
- ☐ **New Business Enrollment Spreadsheet** or **enrollment forms/waivers.** Waivers should be added to the bottom of the spreadsheet; minimum information required on spreadsheet or paper waiver: EE DOB, DOH, and reason for waiving.
- ☐ **If number enrolling is less than 50% of the total number of full time employees, copies of ID cards for valid waivers *could be* requested to verify participation is met. No need to obtain unless notified they are needed.**
- ☐ **Consumer Choice Disclosure Form for groups enrolling in a Navigate plan or Charter plan.**
- ☐ **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) as proof of employment by owner/employer for each 1099 Independent Contractor considered eligible, whether enrolling or waiving.
- ☐ **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, **AND** Plan Summary. The waiver of the waiting period is only available at time of issue.
- ☐ **Required Tax Documentation** – See following page for details
- ☐ **First month's premium check (made payable to UnitedHealthcare) OR** may set up Direct Debit for first month's & subsequent month's premium payments. Please note, all drafts are done on the 10th of the month, so first draft may include premium for 1 or more months. *PLEASE NOTE, ALL GROUPS UNDER 3 ELIGIBLE MUST SET UP DIRECT DEBIT.*
- ☐ **Written Assurance Form** – must be completed by all employers not subject to ERISA (Churches, Federal Non-Federal or Foreign Gov't/Embassies, Indian Tribes)

Send completed materials to:

The Insurance Exchange

15660 Dallas Parkway, Suite 500, LB 60 Dallas, Texas 75248

Attn: Underwriting

Or email to your Sales Rep.

UnitedHealthcare

1 – 50 Required Tax Documentation

ALL GROUPS WITH 2-9 ELIGIBLE:

- Employer's latest quarterly wage & tax report is always required (along with any other states the employer has employees in), unless the company has not been in business long enough to have filed a wage & tax report. Each employee on the report should be noted as full time, part time, terminated, temporary or seasonal as applicable. If wage & tax report not available, must submit company payroll report since inception.** The most recent two week **company payroll is required if there are new hires not appearing on the wage & tax. Must include all employees, not just the new hires. ALL GROUPS OF ONLY 1 ENROLLED SUBSCRIBER MUST PROVIDE IN ADDITION TO THE ABOVE, THE 4 QUARTERLY WAGE & TAX REPORTS FOR THE PREVIOUS CALENDAR YEAR.
- If in business less than one year, submit company formation documents. This may be: An Assumed Name Certificate (Sole Proprietors), Articles of Incorporation, LLC Agreement, or Partnership Agreement. (Whatever legally filed document that shows "owners"). Also need notification letter from IRS of assignment of FEIN.
- If owner(s) not appearing on the wage & tax report, submit previous tax filing year's documentation: 1040 Schedule C (Sole Proprietors), K-1 (S & C Corps), 1120 – pages 1 & 2 including Schedule E (some C Corps). *Must submit K-1s for all owners, to prove 100% of ownership, even if those owners are not actively employed by the company.*
- If 1099s are considered an eligible class and are being offered benefits – in addition to the **1099 Common Law Employee & Fact Attestation Form** 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.

__ACCEPTABLE COMPANY PAYROLL REPORT DOCUMENTATION__ (IN CERTAIN CIRCUMSTANCES WHEN NO WAGE & TAX REPORT IS AVAILABLE AND WHEN NEW HIRES DON'T APPEAR ON TWC REPORT):

- Report must list the company name, and must include the payroll vendor's name and/or logo. If no vendor name or logo on the report, must have a coversheet or letter with the vendor's name.
- Be current and include current pay period dates, and at least 2 weeks of payroll; cannot include future dates.
- List all employees on the same document. NOTE: Separate sheets or pay stubs for each employee is not acceptable.
- Detail gross wages, withholdings and net pay
- Include company totals - a total balance of wages and withholdings
- Churches should submit Federal 941 & payroll report for the same quarter.

__UNACCEPTABLE DOCUMENTATION:__**

- Stock Certificates
- Corporate Minutes
- Letters from Attorney/CPA
- W4s, W2s, W3s, W9s, paystubs or canceled payroll checks

__1 – LIFE OWNER ONLY ELIGIBLE GROUPS:__ AN OWNER ONLY GROUP IS ELIGIBLE, PROVIDED IT IS NOT A SOLE PROPRIETOR. TAX REQUIREMENTS AS OUTLINED ABOVE ARE REQUIRED

__GROUPS WITH 10+ ELIGIBLE:__

- Completed Participation & Floor Certification form can be submitted in lieu of the wage & tax.
- If 1099s are considered an eligible class and are being offered benefits – in addition to the **1099 Common Law Employee & Fact Attestation Form** provide the contract or written agreement between the employer and each contractor, and payment documentation (most recent 12 weeks) as proof of employment by owner/employer for each 1099 Independent Contractor considered eligible, whether enrolling or waiving.

THIS LIST IS NOT ALL-INCLUSIVE. UNITEDHEALTHCARE RESERVES THE RIGHT TO REQUEST ADDITIONAL OR ALTERNATE DOCUMENTS AS NEEDED TO PROVE ELIGIBILITY.

UnitedHealthcare of Texas, Inc.

Additional eligibility requirements:

Corporations: If an owner only and/or owner plus spouse are covered, they are eligible as a group health plan. Two owners who are not spouses qualify as a group health plan in all cases. An additional common law employee is not required to enroll as an owner may be considered a "common law employee" if working full time at the company – i.e. the group may consist of multiple owners only with no full-time employees, where at least 1 owner is actively working and enrolled.

LLC: If an owner only and/or owner plus spouse are covered, they are eligible as a group health plan. Two owners who are not spouses qualify as a group health plan in all cases. An additional common law employee is not required to enroll as an owner may be considered a "common law employee" if working full time at the company – i.e. the group may consist of multiple owners only with no full-time employees, where at least 1 owner is actively working and enrolled.

Sole Proprietorship: When the owner is the only individual, it is not a group health plan. At least 1 common law employee must be enrolled in the plan and a spouse can be considered as the common law employee with proof of full-time status.

Partnership: If only partners and/or partners and their spouses are covered, they are eligible as a group health plan.

One Life Groups (1 enrolled) - Allowed for all business types except Sole Proprietors.

(DO NOT STAPLE)

Employer Application for Small Business

UnitedHealthcare®

UnitedHealthcare Insurance Company
UnitedHealthcare of Texas, Inc.
National Pacific Dental, Inc.

Texas

Notice for Employers who select a Consumer Choice plan: You have the option to choose this Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage or accident and sickness policies in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage or policy.

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable) | Internet Access? ☐Yes ☐No

Contact Person | Email Address | # of Years in Business

Billing Address (If Different) | Telephone | Fax

Multi-Location Group* ☐Yes ☐No | # Locations | Address(es) (or list on additional sheet of paper)

*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

Organization Type ☐Partnership ☐C-Corp ☐S-Corp ☐LLC ☐LLP ☐Sole Proprietor ☐Other_____
Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐Yes ☐No

Medical Benefit Plan Option ☐Calendar Year ☐Policy Year

Domestic Partner Coverage ☐Yes ☐No

Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days)
☐1st of Policy Month following Date of Hire
☐1st of Policy Month following _ ☐months ☐days of employment
☐Date of Hire (no waiting period)
☐ ___ ☐months ☐days of employment following Date of Hire

Waiting Period waived for initial enrollees ☐Yes ☐No

Nature of Business | Industry (SIC) Code

Have Workers' Comp? ☐Yes ☐No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability:
☐See Attached List ☐None

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
# Hours per week to be eligible[1] _____		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
		LTD		LTD		LTD		
		Other		Other		Other		

[1]A person is considered an eligible employee if the employee usually works at least 30 hours per week.

For Disability products the minimum # of work hours per week to be eligible is 30 hours.

Group Name _____

General Information (continued)

☐Yes
☐No

Subject to ERISA? (Most private sector plans are ERISA plans)

If No, please indicate appropriate category:

☐Church (Additional information needed)
☐Indian Tribe – Commercial Business
☐Foreign Government/Foreign Embassy
☐Federal Government
☐Non-Federal Government (State, Local or Tribal Gov.)
☐Non-ERISA Other

UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

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

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

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 full time[1] employees (as defined on page 1).

___ No, we do not offer medical coverage during a leave of absence.

Consumer Driven Health Plan Options

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

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?

Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.

HRA ☐ Yes ☐ No

If yes, please identify type: ☐ UnitedHealthcare HRA (any HRA design offered through UnitedHealthcare) ☐Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

Questions Regarding Group Size

☐COBRA ☐State Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year. If your group had fewer than 20 employees during a calendar year, you must provide State Continuation effective January 1 of the next calendar year.
☐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.
Enter the Prior Calendar Year Average Total Number of Employees ☐	Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee 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 employee 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 employees 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).
Enter the Prior Calendar Year Total Number of Eligible Employees ☐	For purposes of determining your number of eligible employees, Eligible employees are those who are eligible to enroll in any medical plan you offer, even if they aren't eligible to enroll in a UnitedHealthcare plan. Here you may add COBRA and retirees. Calculate your number of eligible employees from the preceding calendar year: (1) Count the total number of eligible employees at the end of each month (2) Add all the monthly eligible totals from line (1) and divide by 12. Use whole numbers only (no decimals, fractions or ranges and round down).

Group Name _____

Questions Regarding Group Size (continued)

Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees ☐	For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.
☐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 that 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 employer? If you answered Yes, then indicate which of the following most closely describes your plan: ☐Professional Employer Organization (PEO) ☐Governmental ☐Multiple Employer Welfare Arrangement (MEWA) ☐Church ☐Taft Hartley Union ☐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.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months? ☐Yes ☐No If Yes, please provide policy number _____ and Coverage Begin Date ___/___/___ End Date___/___/___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐Yes ☐No

		Name of Carrier	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐None			
Current Dental Carrier	☐None			
Current Life Carrier	☐None			
Current Disability Carrier	☐None			
Current Vision Carrier	☐None			

Texas Mandatory Disclosure Statement

Dental indemnity benefits are provided through UnitedHealthcare Insurance Company and Dental HMO (DHMO) benefits are offered through National Pacific Dental, Inc. In order to receive benefits from the DHMO plan, an enrollee must utilize only network providers, except for emergency dental care, and pay the copayments specified in the evidence of coverage or certificate. To receive benefits under the dental indemnity plan, the enrollee may utilize any provider but prior to receiving reimbursement, the enrollee must meet the required deductible and is responsible for the coinsurance amount specified in the evidence of coverage or certificate.

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company (PPO, indemnity) or UnitedHealthcare of Texas, Inc. (HMO)
Dental coverage provided by UnitedHealthcare Insurance Company (indemnity) or National Pacific Dental, Inc. (HMO)
Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Group Name _____

Important Information

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any intentional misrepresentation, fraudulent statement, or omission that constitutes fraud may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Knowingly or willfully presenting a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presenting false information, or concealing information for the purpose of misleading, in an application for insurance, is a crime punishable by fines and confinement in prison.

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, if applicable, are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Please note, that to the extent permitted by applicable State law, an employer's failure to pay any past-due premium amounts owed for coverage to this health insurer to whom you are applying for coverage, or any other health insurance company within this health insurer's control group, within the past 12 months preceding the requested effective date of any new coverage, will be assigned to the employer's initial premium payment and the prior premium debt owed will be considered paid first in line before the new policy premium amount in order to effectuate new coverage.

Signature

Group Authorized Signature	Title	Date

Producer Information (if applicable)

Writing Producer Name	Writing Producer SSN		Is the Producer appointed with UHC? ☐ Yes ☐ No
All Payments to:	CRID Code (for internal use)	Tax ID	If more than 1 Producer*, Split _____ %

Street Address	City	State	Zip Code

Producer Phone #	Producer Email Address	Producer Fax Number

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	**Producer Signature**	**Date**

*If more than one Producer, provide the second Producer's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Information (if applicable)

General Agent	Phone #	Franchise Code	
The Insurance Exchange	(972) 991-6500	0000234	
Street Address	**City**	**State**	**Zip Code**
15660 Dallas Parkway #500 LB 60	Dallas	TX	75248

UnitedHealthcare®
A UnitedHealth Group Company

Prime Binder check detail

Customer/Group name: _____

Tax ID # _____

Effective Date _____

Check # _____

Check Amount _____

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

Please remit payment to the following lockbox for **all markets except CA**:

Regular Mail:
UHS Premium Billing
P.O. Box 94017
Palatine, IL 60094-4017

Overnight Mail:
UHS Premium Billing
Attn: Box 94017
5505 N. Cumberland Ave Ste 307
Chicago, IL 60656-1471

Please remit payment to the following lockbox for **CA market**:

Regular Mail:
UHIC – UnitedHealthcare of CA
P.O. Box 843118
Los Angeles, CA 90084-3118

Overnight Mail:
UHIC – UnitedHealthcare of CA
Wells Fargo Bank E2001-049
Lockbox 843118
3440 Flair Drive
El Monte, CA 91731

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!

Employer eServices Scheduled Direct Debit

Sign up for UnitedHealthcare Scheduled Direct Debit to automatically deduct your premium payments from your bank account.

Streamline your monthly invoice payment process

Scheduled Direct Debit from Employer eServices® is a convenient way to pay your monthly insurance premiums.

After you sign up, your premium will be automatically deducted from your company's bank account.

Even better, Scheduled Direct Debit helps you streamline your monthly invoice payment process and better organize your payment records, which frees you up to focus on the business of your business.

Scheduled Direct Debit takes care of everything automatically, which may help you:

- Pay your premium at the same time, on time, each month
- Maintain a consistent process for your payments
- Better predict cash outflow
- Access an accurate record of your payments, which are listed on your bank statement

Enroll today and worry about one less thing tomorrow

To enroll:

1. Complete the Scheduled Direct Debit Authorization Form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.
3. Return the completed form by email or fax. Contact information is listed on the form.

IMPORTANT: Please return the completed form along with a voided check (no deposit slips, please) or an authorized bank letter.

Printed name and title of signatory	Date
Employer name/Customer name/Policy name	Employer email address
UnitedHealthcare customer number	UnitedHealthcare bill group(s)
Name of your financial institution	Telephone number of financial institution
Routing/Transit Number (9 digits required)	Account number (include all zeros and omit spaces/special characters)

Email to: Direct_Debit@uhc.com

Fax to: 1-888-476-5127
Attn: Accounts Receivable

continued

United Healthcare

Statement of understanding

This agreement is made in accordance with the operating rules and regulations of the National Automated Clearinghouse Association. By executing this document in the space provided above, I confirm that I am authorized to act on behalf of the employer/customer ("Group") and agree on behalf of the Group to the following terms and conditions:

- **By choosing Scheduled Direct Debit, the customer understands all invoicing will be online only located at employereservices.com. Should there be any questions pertaining to accessing and/or location of the invoice, please call 1-800-651-5465, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.**
- Group authorizes UnitedHealthcare to debit the group checking or savings (account number provided above) for all monthly charges for coverage.
- Group understands that it may take up to one month to set up Scheduled Direct Debit and consequently all overdue premiums should be promptly paid in order to avoid receiving a delinquency letter and possible termination of your account during this initial set up period.
- Group understands and agrees that it will have sufficient funds in its account to cover the full premium invoice on the draft due date. If necessary funds are not in your account on the draft due date, group coverage may be subject to termination proceedings consistent with the terms stated in your UnitedHealthcare contract.
- Group understands that the amount drafted may vary based on billing premium adjustments reflected on your monthly invoice.
- Group understands UnitedHealthcare may make adjustments to the account whenever a correction or change is required. For example, if there is an error, the group/member agrees that UnitedHealthcare may correct the error immediately and without notice. Such errors may include, but are not limited to, reversing an improper credit, making adjustments for returned premium, and correcting calculation and input errors. The right to make adjustments are not subject to any limitations or time constraints, except required by law.
- Payment will be withdrawn on the date indicated on your monthly invoice.
- Group agrees to promptly notify UnitedHealthcare of any change to the information provided.

Authorization

Authorization is given to UnitedHealthcare to initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to UnitedHealthcare; it is canceled by UnitedHealthcare under the conditions stated above; or upon termination of coverage with UnitedHealthcare.

_____

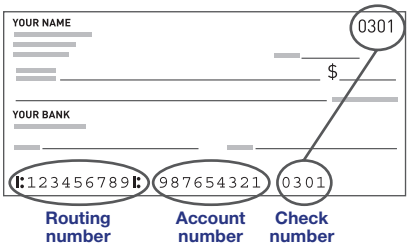
Signature required

Determining your routing number

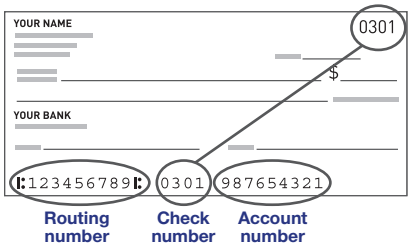
To determine your routing number, refer to your company check. The routing number is always 9 digits long and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank.

For example:

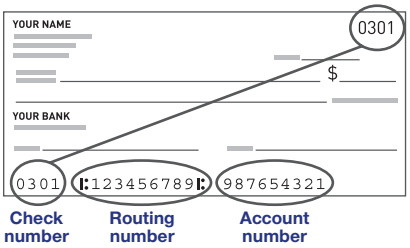
Bank 1



Bank 2



Bank 3



Please contact your financial institution if you have any questions about your routing number or account number.

United Healthcare

Health Plan coverage provided by or through a UnitedHealthcare company.
Administrative services are provided by United HealthCare Services, Inc. or their affiliates.
B2C EI211188662.0 11/21 © 2021 United HealthCare Services, Inc. All Rights Reserved. 21-1188318-B

Texas Small Business
Groups with 1-50 ATNE

Product and Benefit Selection Form

UnitedHealthcare Multi-Choice®

UnitedHealthcare®

Billing Type

☐ Paper billing ☐ Online only/e-Bill ☐ Electronic Funds Transfer

****Billing cycle – For 15th of the month effective date, please select 1st or 15th of the month billing cycle:** ☐ 1st ☐ 15th

PLEASE NOTE: **Please refer to the Health Plan Product Offering for a complete list of the Multi-choice packages available. Please indicate which package and the plans within the package that are being offered to employees. A group may offer multiple plans; however, they must be within the same package.**

Medical Plan

☐ **Package Number** _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code_____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

☐ Medical Plan Code _____ RX Code _____

*If an HSA plan is selected, which bank will be used?

☐ OptumBank℠ Other _____

This form is not considered complete until the last page is signed and dated.

Dental Plan

☐ Plan Code_____ ☐ Not elected

☐ Plan Code_____ ☐ Not elected

Vision Plan

☐ Plan Code_____ ☐ Not elected

☐ Plan Code_____ ☐ Not elected

Basic Life Amount

Employee:

☐ Flat Amounts $_____ ☐ Not elected

☐ 1x Salary

☐ 2x Salary

Dependent:

☐ Spouse $_____ ☐ Not elected

☐ Child(ren) $ _____

Please indicate salary amount on enrollment form for each employee for multiple of salary life.

Supplemental Coverage

Life/AD&D $_____ STD/LTD $_____ (Indicate plan codes)

Life/AD&D $_____ STD/LTD $_____ (Indicate plan codes)

Life/AD&D $_____ STD/LTD $_____ (Indicate plan codes)

- Complete addendum to Employer Application for Supplemental Life and Disability Lines of Coverage.
- Life/AD&D applies to groups with over 10 eligibles; maximum amount is $100,000.
- Supplemental Life must be sold with Basic Life.
- Please indicate salary amount on enrollment form for each employee for disability and multiple of salary life.

Optional State Rider Selection

Please review the offers below and indicate your acceptance or rejection. **Additional premium will be charged for the additional benefits chosen.**

In Vitro Fertilization

A health benefit that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures. Benefits for in vitro fertilization procedures must be provided to the same extent as benefits provided for other pregnancy-related procedures under the plan. The coverage is required only if the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan; the fertilization or attempted fertilization of the patient's ocytes is made only with the sperm of the patient's spouse; the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with endometriosis, exposure in utero to diethylstilbestrol (DES), blockage of or surgical removal of one or both fallopian tubes, or oligospermia; the patient has been unable to attain a successful pregnancy through any less-costly applicable infertility treatments for which coverage is available under the group health benefit plan; and the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.

In Vitro Fertilization: ☐ Accept ☐ Reject

Texas plans only

Signature

TEXAS INSURANCE LAWS REQUIRE ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN TEXAS TO SMALL EMPLOYERS OF 1-50 (ATNE) EMPLOYEES INCLUDING A BASIC OR STANDARD HEALTH BENEFIT, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. The answers provided in this Product and Benefit Selection Form are accurate and complete to the best of my knowledge and belief, and the Insurer shall rely and act upon them accordingly.
This Product and Benefit Selection Form must accompany the Employer Application for Small Business.
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.

Employer Signature	Group Name	Date Signed

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UnitedHealthcare®

TDI | Texas Department of Insurance

UNITEDHEALTHCARE OF TEXAS, INC.

Consumer Choice Plan Disclosure Statement (Form CCP1)

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for in-network care.
Out-of-pocket costs The amount you pay when you receive care, up to an annual limit.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for occupational therapy and physical therapy, except for the treatment of Acquired Brain Injury and Autism Spectrum Disorders.	Has no limit on the amount of care if it is needed for medical reasons.
Home Health Care services Skilled Care services received in the home.	Includes a limit on the number of visits per year.	Has no limit on the amount of care if it is needed for medical reasons.

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits.

To learn more about this plan, call 1-866-414-1959 or visit www.uhc.com.

By signing this form, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Don't sign this document if you don't understand it.
No firme este documento si no lo comprende.

Print the name of the person applying: _____

Signature of the person applying: _____

Date of signature: _____

Name of business, if applicable: _____

UnitedHealthcare of Texas, Inc. must give you a copy of this statement upon request.

Participation & Floor Certification

[Groups with 10+ Eligible Employees]

UnitedHealthcare®

General Information		
Group's Legal Name		
Full Address (Street, City, State, Zip)		
Requested Effective Date		
Floor Calculation (AL, AR, AZ, DC, GA, IA, ID, IL, IN, KS, KY, LA, MO, MS, NC, NM, ND, OH, PA, SC, SD, TN, UT, VT)		
1	Number of employees enrolling in UnitedHealthcare group medical policy	
2	Number of eligible (full time) employees	
3	Divide line 1 by line 2. This is your **floor participation percentage.**	%
Participation Calculation (AK, CA, CO, CT, DE, FL, HI, MA, MD, ME, MI, MN, MT, NE, NH, NJ, NV, NY, OK, OR, RI, SC, TX, VA, VI, WA, WV, WI, WY)		
1	Number of eligible (full time) employees	
2	Number of eligible (full time) employees with a valid waiver reason	
3	Subtract line 2 from line 1. This is your **total eligible count.**	
4	Number of employees enrolling in UnitedHealthcare group medical policy	
5	Divide line 4 by line 3. This is your **participation percentage.**	%

Important Information

UnitedHealthcare reserves the right to review the applicant's payroll/wage & tax records at any time to confirm eligibility. UnitedHealthcare may request the applicant's most recent wage & 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.

Signature

By signing this form, I hereby certify, as a condition of eligibility, that the Group is in compliance with the minimum participation requirements as expressed in the group policy. UnitedHealthcare reserves the right to request and review payroll or other documentation confirming compliance. I represent that the information I have provided is accurate and truthful. I understand that any intentional misrepresentation of material fact or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Group Authorized Signature	Title	Date

Common Ownership Certification

Please complete, sign and submit the Common Ownership Certification.

Renewing Groups- 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. *When listing the number of Eligible, count the number of Eligible employees for each business, even if they're not offered this insurance.

Customer Name: _____

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) & Title:	Signature:	Date:

Common Law Employee and Fact Attestation Form

Your fully insured small 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, 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) are 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 workers 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

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 # _____

ASSURANCE AS TO USE OF PREMIUM REBATE

POLICYHOLDER:

POLICY NUMBER:
(the "Policy")

ASSURANCE EFFECTIVE TERM:
Unless earlier revoked by Policyholder, from the date signed until the end of the final policy year of the Policy.

INSURER:
("UHC")

I, the undersigned, state that I am an authorized representative of Policyholder and have authority to provide this Assurance on Policyholder's behalf. Policyholder is not a governmental plan, nor is it a plan covered by the Employee Retirement Income Security Act. Therefore, pursuant to the provisions of 45 CFR § 158.242(b)(3), Policyholder hereby provides written Assurance to UHC that Policyholder will use any premium rebate it receives from UHC during the Assurance Effective Term (a "Rebate") as stated below.

Policyholder agrees to use a portion of the Rebate received during any calendar year for the benefit of its subscribers in one of the ways listed below, to be selected at Policyholder's discretion. The amount of the Rebate used for the benefit of the subscribers (described below) shall be proportionate to the actual contribution to premiums made by subscribers in the year for which the MLR rebate was derived.

(1) To reduce the portion of premium owed by the subscribers of any health plan offered by Policyholder during the policy year immediately following the year in which the rebate is received;

(2) To reduce the portion of premium owed by only the subscribers covered by the Policy for the policy year immediately following the year in which the rebate is received; or

(3) A cash refund to only the subscribers covered by the Policy; or

(4) Other method of distribution to subscribers expressly permitted under any amendment or revision to 45 CFR § 158.242(b)(3) in effect at the time of rebate distribution.

The subscriber benefit may be divided equally among all eligible subscribers, divided based on each subscriber's actual contributions to premium or divided in some other manner that reasonably reflects each subscriber's contribution to premium. In addition, any portion of a Rebate based upon former subscribers' contributions to premium shall be aggregated and used for the benefit of current subscribers as permitted above.

Policyholder acknowledges that it is aware that it may revoke this Assurance at any time by providing written notice to UHC; however, doing so will mean that any subsequent premium rebates owed by UHC with relation to the Policy will be paid directly to the applicable subscribers.

A signature by facsimile transmission or any other electronic means that allows the identity of the signer to be reasonably confirmed is as good and binding as an original signature.

_____ Date: _____
Signature

_____ _____
Print Name Title

(DO NOT STAPLE)

Employee Enrollment Form
Texas

UnitedHealthcare

UnitedHealthcare Insurance Company
UnitedHealthcare of Texas, Inc.
National Pacific Dental, Inc.

Notice for Employers who select a Consumer Choice plan: You have the option to choose this Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage or accident and sickness policies in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage or policy.

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed By Employer — **Requested Effective Date of Coverage/Date of Change** / /

Group Name

Policy Number

Date of Hire

Position/Title

Hours Worked per week

Salary $ _____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
☐ New Group Plan ☐ New Hire
☐ Life Event/Date _____ ☐ Annual Open Enrollment
☐ Status Change _____
☐ Dependent Add/Delete
☐ Change Name/Address ☐ Late Enrollee
☐ Part time to Full time
☐ Waiving Coverage ☐ Termination
☐ Other _____

Employee Type
(Check all that apply)
☐ Active ☐ COBRA ☐ State Continuation
Start dt ____/____/____
End dt ____/____/____
☐ Hourly ☐ Salary
☐ Union ☐ Non-Union ☐ Retired
☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and B.

Last Name | First Name | MI | Social Security Number ___-___-____

Address | Apt # | City | State | Zip Code

Home Phone

Cell Phone

Work Phone

Date of Birth / /

Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Language Preference, if not English _____

Email Address:

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

Primary Care Physician[2]
Physician First & Last Name _____
Address _____
ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___
Existing Patient? ☐ Yes ☐ No
You may select an obstetrician or gynecologist in addition to your Primary Care Physician. However, obstetrical or gynecological care may be received from your Primary Care Physician.

Primary Care Dentist[3]
Dentist First & Last Name _____
ID# _____
Existing Patient? ☐ Yes ☐ No

B. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date | Employee Signature if waiving all coverage

Employee Name ______________________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Spouse /Domestic Partner				☐M ☐F	/ /
	Social Security Number:			—		—					Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[2]
Existing Patient? ☐Yes ☐No
Physician First & Last Name ____________________
Address ____________________
ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No
Dentist First & Last Name ____________________
ID# ____________________

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number:			—		—					Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[2]
Existing Patient? ☐Yes ☐No
Physician First & Last Name ____________________
Address ____________________
ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number:			—		—					Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[2]
Existing Patient? ☐Yes ☐No
Physician First & Last Name ____________________
Address ____________________
ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number:			—		—					Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[2]
Existing Patient? ☐Yes ☐No
Physician First & Last Name ____________________
Address ____________________
ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /
	Social Security Number:			—		—					Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No			

Primary Care Physician[2]
Existing Patient? ☐Yes ☐No
Physician First & Last Name ____________________
Address ____________________
ID# __ __ __ __ __ __ __ __ __ __ __ – __ __ __ __

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No
Dentist First & Last Name ____________________
ID# ____________________
Permanently disabled and age 26 or older[5] ☐Yes ☐No

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Health Maintenance Orgnaization (HMO) products, including Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Employee Name _____

D. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Employee	☐ _____	☐ _____	☐	☐$_____	☐$_____
Spouse/Domestic Partner	☐	☐	☐	☐$_____	☐$_____
Dependent	☐	☐	☐	☐$_____	☐$_____

Person	STD	LTD
Employee	☐	☐

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)	Relationship
Primary	
Secondary	

E. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___ ___ ___ End date ___ ___ ___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

F. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___ ___ ___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

G. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare 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.

Please note that if you knowingly or intentionally leave out information or make a misrepresentation of a material fact on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

Texas Mandatory Disclosure Statement

Dental indemnity benefits are provided through UnitedHealthcare Insurance Company and Dental HMO (DHMO) benefits are offered through National Pacific Dental, Inc. In order to receive benefits from the DHMO plan, an enrollee must utilize only network providers, except for emergency dental care, and pay the copayments specified in the evidence of coverage or certificate. To receive benefits under the dental indemnity plan, the enrollee may utilize any provider but prior to receiving reimbursement, the enrollee must meet the required deductible and is responsible for the coinsurance amount specified in the evidence of coverage or certificate.

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify _____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Coverage Provided by "UnitedHealthcare and Affiliates": Medical coverage provided by UnitedHealthcare Insurance Company (PPO, indemnity) or UnitedHealthcare of Texas, Inc. (HMO). Dental coverage provided by UnitedHealthcare Insurance Company (indemnity) or National Pacific Dental, Inc. (HMO). Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company. Vision coverage provided by UnitedHealthcare Insurance Company.