Florida — New business checklist

Please use the sales automation management (SAMx) tool for all 2–50 quoting and enrollment. Visit **uhceservices.com** and access the SAMx tab for faster quoting and case submission.

Forms

Employer application

The UnitedHealthcare group application form must be completed and signed both by the employer and agent. Only completed original group applications will be accepted.

Enrollment spreadsheet

Enrollment forms not required if spreadsheet is used. Do not include waivers on spreadsheet.

Employee applications

If an enrollment spreadsheet is not used, member enrollment forms must be completed (including the employee section at the top of the form), dated and signed for all eligible employees, including those waiving coverage.

COBRA enrollees are not counted as eligible employees when determining group size.

Waivers must be completed, signed and dated by the employee.

Valid Waivers
Individual, Individual Exchange, Spousal, Champus (Military), Tricare, VA, Other group coverage from a different employer, Retiree through group coverage, COBRA from previous employer, Medicare, Parents, Foreign Government coverage, UnitedHealth One & Religious Beliefs.

Invalid Waivers
Medicaid, Cost, Do not want or Other Group Coverage from the same employer.

Product selection form*

The product selection form must be completed and signed by the employer.

*Not required if installing group in SAMx.

Please note

Proposed rates are based on census data originally submitted and are valid only for those employees and dependents who reside or work in the designated service area. Final rates will be based on actual enrollment on the effective date of coverage. No group should cancel their coverage until they have received approval and final rates from UnitedHealthcare.

UnitedHealthcare Insurance Company and/or Neighborhood Health Partnership, Inc. will be the sole carrier(s) for medical benefits.

If not appointed with UnitedHealthcare, quote requests must be emailed to **sequotes@uhc.com.**

continued

Financial

Contribution

Minimum employer contribution is 50% of the single employee rate on selected plan.

Binder check

Binder checks with first month premium required with application. Please include tax ID on the check and mail to the following location:

Standard address:
UHS Premium Billing
PO Box 94017
Palatine, IL 60094-4017

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

RT-6

If required to file an RT-6, UnitedHealthcare/Neighborhood Health Partnership requires all groups with fewer than 10 eligible subscribers to submit a signed copy of their current RT-6/quarterly wage and tax report with their new business submissions. Groups with 10–50 eligible subscribers may submit the Participation Certification form in lieu of the RT-6 and/or payroll. For groups with PEO, affiliate or common ownership, additional documentation may apply. Please contact your local account executive. All enrollees must appear on the submitted, filed tax documents unless they are new hires and their date of employment falls within the preceding quarter. If not required to file an RT-6, the most current payroll statement, 1 document from (see below) Box A (if applicable for your business), and 1 from Box B are required to establish eligibility.

All self-employed individuals and sole proprietors must be able to document taxable income in 1 of the 2 previous years as indicated on IRS Form 1040 Schedule C or F. If the previous year's tax documentation is not available, requests for a tax filing extension will be accepted, subject to providing the most current payroll statement. All tax documents must be signed copies of the original documents or, if submitted electronically, a copy of the document with a copy of the electronic acknowledgment.

Box A	Box B
Current business, state, or occupation or occupation's license Articles of incorporation Partnership agreements	IRS Form 941 (not-for-profit use only) IRS Form 1040 (with a Schedule C or F) IRS Form 1065 – Partnership Income (with K-1) IRS Form 1121/1120S – Corporate Income (with K-1)

Participation

50% minimum participation

All 2–50 employer groups must meet a 50% participation requirement (after valid waivers) for new business eligibility. For example, if an employer group has 20 total employees with 10 valid waivers, then 50% of the remaining 10 eligible employees equals 5. The group must enroll a minimum of 5 employees to meet the 50% participation requirement.

Eligible employees

Eligible employees are those employees who are working a minimum of 25 hours per week and who have satisfied any waiting period as required by the employer. Employees in their waiting period are not eligible.
When determining if adequate participation levels are met, UnitedHealthcare does not count as eligible any employee who has qualifying existing coverage in another employer-based group insurance plan or an ERISA qualified self-insured plan.

1099

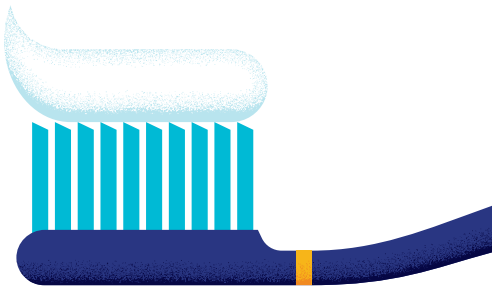
Individual contractors paid by 1099 are eligible for coverage, providing specific guidelines are met.

continued

Submission deadline

UnitedHealthcare/Neighborhood Health Partnership may request additional documentation if needed to establish eligibility. All required information must be submitted to process the case by the requested effective date.

Effective dates are the first and 15th of the month. Any cases with missing information may delay processing for the requested effective date.



Ancillary

UnitedHealthcare Insurance Company will be the sole carrier for dental and life products. The employer must meet the following eligible employee participation and contribution requirements for dental, vision, life and disability.

Contributory plans

Dental: Employer contributes at least 50% of the single rate and a minimum of 75% participation, not to fall below 50% of total eligible.

Vision: Employer contributes a minimum of 75% on employer paid plans, 50% on contributory plans and at least 75% participation, not to fall below 50% total eligible.

Basic life: Employer contributes a minimum of 25% and a minimum of 75% participation.

Disability: Contributory plans available for groups with a minimum of 10 eligible subscribers. Employer contributes a minimum of 25% and 50% minimum participation.

Voluntary plans

Dental: Maximum contribution of 49% with a minimum of 2 enrolled on plans without ortho and a minimum of 8 enrolled on plans with ortho.

Vision: Maximum contribution of 49% and a minimum of 1 enrolled.

Supplemental life: Available to groups with a minimum of 10 eligible, and must be sold with basic life and a minimum of 25% participation (no employer contribution).

Disability: Available to groups with a minimum of 10 eligible and minimum of 25% participation (no employer contribution).

Learn more

For more information, please contact your local representative

United Healthcare

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.

_____

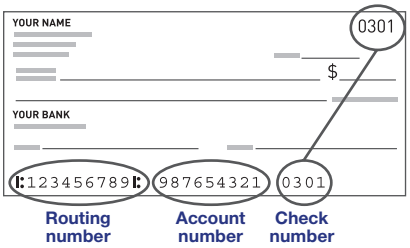
Signature required

Determining your routing number

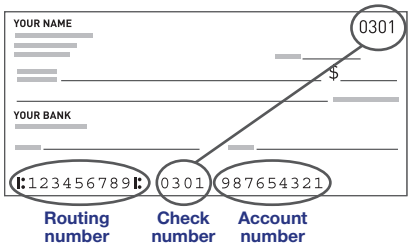
To determine your routing number, refer to your company check. The routing number is always 9 digits long and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank.

For example:

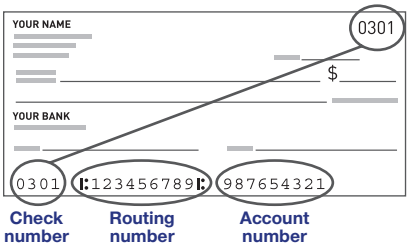
Bank 1



Bank 2



Bank 3



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

United Healthcare

New Business Binder Check Coversheet

Group Name	
Federal TAX ID#	
Group Number	
Policy Eff Date	
Check #	
Amount#	

Ensure check is written out to UHC
Include customer name & TAX ID # on check
Send check to below address

Street Address:	**Overnight Address:**
UHS Premium billing **PO Box 94017** **Palatine, IL 60094-4017**	**UHS Premium Billing** **Attn: Box 94017** **5505 N. Cumberland Ave. Suite 307** **Chicago, IL 60656-1471**

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

Product and Benefit Selection Form (1-100)

UnitedHealthcare

1. Group Name _____ Effective Date _____

2. Medical Plan Code(s)	Rx Plan Code(s)	Rates - EE Only	EE + Spouse	EE + Child	EE + Family

3a. Dental Plan Code(s)	Rates - EE Only	EE + Spouse	EE + Child	EE + Family

3b. Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

If yes, name of carrier _____

☐ Prior Carrier Invoice ☐ Copy of Current/Prior Benefits

4. Vision Plan Code	Rates - EE Only	EE + Spouse	EE + Child	EE + Family

5. Life Amount(s) in dollars

Employee* _____

Spouse _____

Child(ren) _____

Acceptance of this application will replace existing life insurance coverage. ☐ Yes ☐ No

*25K minimum life amount required to qualify for packaged savings for a life /medical sale

6. Supplemental Coverage(s)

Sup Life _____

STD

LTD

Accident** _____

Critical Illness** _____

**Limited Availability

7. Other Notes

8. Required Documents for Case Installation

- ☐ Employer Form
- ☐ Enrollment Spreadsheet (or Employee Applications if required)
- ☐ Sold proposal
- ☐ Copy of Binder Check
- ☐ Wage & Tax and Ownership Paperwork (Schedule C, K1 - if owners enrolling and not on W&T) 1-9 eligible only
- ☐ Participation Certification 10-50 eligible only
- ☐ Billing Service Agreement (51+ only, if applicable) Service Fee Amount_____%

Signature

Employer Signature	Title	Date

UHC Account Executive: _____

ver060517

(DO NOT STAPLE)

Employer Application for Small Business

Florida

☐ UnitedHealthcare Insurance Company
☐ UnitedHealthcare of Florida, Inc.
☐ Neighborhood Health Partnership, Inc.
☐ All Savers Insurance Company

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 Did you have at least one non-spouse common-law employee during the prior calendar year? ☐Yes ☐No	Medical Benefit Plan Option ☐Calendar Year ☐Policy Year	Domestic Partner Coverage ☐Yes ☐No Same sex ☐Yes ☐No Opposite sex ☐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	Waiting Period for Rehires: ☐Yes ☐No If yes, waived if rehired within _____months.

Classes Excluded: ☐None ☐Union ☐Hourly ☐Non-Management ☐Salary	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

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Florida, Inc., Neighborhood Health Partnership, Inc., and All Savers Insurance Company.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Group Name _____

General Information (continued)

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_____		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
For Disability products the minimum # of work hours per week to be eligible is 30 hours.		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		

☐ Yes
☐ No

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

If No, please indicate appropriate category:

☐ Church (additional information needed) ☐ Federal Government
☐ Indian Tribe – commercial business ☐ Non-Federal Government (state, local or tribal gov.)
☐ Foreign Government/Foreign Embassy ☐ 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 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 employees.

___ 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.

Are you offering employees ICRHA (individual coverage health reimbursement account)? ☐ Yes ☐ No

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.

Group Name _____

Questions Regarding Group Size (continued)

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).
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 an Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?
☐ Yes ☐ No	Is your group an 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 an 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: ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Church ☐ Taft Hartley Union ☐ Employer association ☐ Governmental
☐ 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			

Group Name _____

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the group's employees. This consent remains in effect until it is withdrawn. The group may withdraw their consent at any time or request a document in a paper or non-electronic form.

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.

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, or conceals information for the purpose of misleading, in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.

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.

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.

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

Florida License ID#	To the best of my knowledge, acceptance of this application will replace existing life insurance coverage. ☐ Yes ☐ No

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.

UnitedHealthcare Sales Representative/Account Executive

Sales Representative Or Account Executive (First & Last Name)

General Agent Information (if applicable)

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

(DO NOT STAPLE)

Employee Enrollment Form
Florida

United Healthcare

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 ☐ U

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

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

To select paperless delivery complete and sign the enrollment form and provide your email address.
Check here to receive your required plan communications by mail ☐

Primary Care Physician[3] Existing Patient? ☐ Yes ☐ No

Physician first & last name _____

Address _____

ID# _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

Primary Care Dentist[4]

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

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Florida, Inc., Neighborhood Health Partnership, Inc., and All Savers Insurance Company.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name ______________________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[5] Spouse /Domestic Partner	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
	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[3] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

Primary Care Dentist[4] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[6] ☐ Yes ☐ No

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Relationship[5] Dependent	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
	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[3] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

Primary Care Dentist[4] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[6] ☐ Yes ☐ No

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Relationship[5] Dependent	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
	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[3] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

Primary Care Dentist[4] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[6] ☐ Yes ☐ No

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Relationship[5] Dependent	Last Name	First Name	MI	Sex ☐ M ☐ F ☐ U	Date of Birth / /
	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[3] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name ______________________
Address ______________________
ID# _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

Primary Care Dentist[4] Existing Patient? ☐ Yes ☐ No
Dentist First & Last Name ______________________
ID# ______________________
Permanently disabled and age 26 or older[6] ☐ Yes ☐ No

Race/Ethnicity – Check all that apply[2] ☐ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code

Employee name _____

C. Family Information (continued)

List all enrolling (attach sheet if necessary)

Relationship[5] Dependent	Last Name	First Name	MI	Sex ☐M ☐F ☐U	Date of Birth / /
	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[3] Existing Patient? ☐Yes ☐No

Physician First & Last Name _____

Address _____

ID# _ _ _ _ _ _ _ _ _ _ _ – _ _ _ _

Primary Care Dentist[4] Existing Patient? ☐Yes ☐No

Dentist First & Last Name _____

ID# _____

Permanently disabled and age 26 or older[6] ☐Yes ☐No

Race/Ethnicity – Check all that apply[2] ☐Prefer not to answer ☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other–Please specify

ZIP code

(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) Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination. (3) For UnitedHealthcare 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. (4) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (5) 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. (6) 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.

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.

F. Other Medical Coverage Information (continued)

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

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 24 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.

G. Signature (continued)

Please note that if you leave out information or make a misrepresentation 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.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health or health-related procedures, products and services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

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.

Please maintain a copy of this authorization for your records.

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