Georgia 2-50 Fully Insured

Submission Checklist

Submit Electronically via SAMx or Benefitter

Submit Manually: Email to: SESUB@uhc.com and cc your Account Executive

Groups with 2-50 Full Time Employees

Items needed for Installation:

- ✓ Employer Application
- ✓ Image of Binder Check
- ✓ Product Selection Form
- ✓ Participation Certificate (For Groups 10-50)
- ✓ Enrollment Spreadsheet (Not Attached, Used for Groups 5+)

If Applicable

- ✓ Common Ownership Form

After Welcome Letter is issued Mail Binder check to:

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

UnitedHealthcare®

(DO NOT STAPLE)

Employer Application for Small Business

Georgia

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

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

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc. or UnitedHealthcare Insurance Company of the River Valley
Dental coverage provided by UnitedHealthcare Insurance Company
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 _____

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) ☐ 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.
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).

Group name _____

Questions Regarding Group Size (continued)

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 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			

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.

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 agentor 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

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

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 _____%

9. Does the group currently use Electronic Data Interchange (EDI)? If so, what vendor? ☐ Yes ☐ No _____

10. Dual Waiting Period (Y/N) ____ If yes, indicate dual waiting period _____

If 'Yes' were answered for question 10 and/or 11, please reflect on eligibility file.

Signature

Employer Signature	Title	Date

UHC Account Executive

UnitedHealthcare®
A UnitedHealth Group Company

Binder check detail

Customer/Group name: _____

Tax ID # _____

Effective Date _____

Check # _____

Check Amount _____

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. Thank you!

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: