

# Broker Checklist for Preliminary Quote & Case Submission (rev. 05/23)

Thank you for your new group request for proposal (RFP) and submission.

The following items are required for **preliminary quoting**. Incomplete items may cause delays.

☐ **Agency information:**

- ☐ Writing agent name
- ☐ Agency name
- ☐ Agency full address
- ☐ Email address where we can send the completed quote
- ☐ Your UnitedHealthcare Account Executive's name

☐ **Group Information:**

- ☐ Group name
- ☐ Group's physical address with ZIP code
- ☐ SIC code or type of industry
- ☐ Requested effective date
- ☐ Employer tax ID number (TIN)
- ☐ Full time equivalent total number of employees. Refer to page 3 of the [Employer App Non-HMO](#) or [HMO](#) for details on how to calculate the FTE number. See note below for further information on full-time employees.
- ☐ If the request is a carve out, indicate the number of employees for the carve out and the number of employees who would be eligible if the coverage were offered to all employees.
- ☐ Requested product lines and benefits: medical, dental, vision, life, short-term disability (STD), and long-term disability (LTD).
- ☐ Current carrier name for requested product lines (indicate if group has any current coverage with UnitedHealthcare).
- ☐ COBRA enrollees indicated on the census.
- ☐ Employee census — Excel format should include each member's name, relationship, gender, date of birth (including all dependents), state/ZIP code and product selections. Example shown below:

UnitedHealthcare Quote Request Census													
Include all full-time employees enrolling. Enter each member (EE, SP or CH) on a separate line.													
Relationship	Last Name	First Name	Gender	Date of Birth	State	ZIP	Medical	Dental	Vision	Life	STD	LTD	Annual Salary
EE	Example A	Employee	M	12/34/5678	NM	87113	Y	Y	Y	Y	Y	Y	\$-
SP	Example A	Spouse	F	12/34/5678			Y	Y	Y	N			
CH	Example A	Child	M	12/34/5678			Y	Y	N	N			
CH	Example A	Child	F	12/34/5678			Y	Y	N	N			
EE	Example B	Employee	M	12/34/5678	NM	87113	Y	Y	Y	Y	Y	Y	\$-
SP	Example B	Spouse	F	12/34/5678			N	Y	Y	N			

**NOTE:** A full-time employee is one who actively works on a full-time basis (per state guidelines), is earning at least minimum wage per the Fair Labor Standards Act, and is referred to as a "common law employee" under Health Care Reform (HCR) guidelines. Refer to the [NM Tax Documentation Guidelines](#) for details on common law employees. The following are not eligible for coverage: Part-time employees, volunteers, and seasonal employees who are not working the required hours per week, are not on the wage & tax, and have not satisfied the waiting period.



## Case installation of a 2-50 sold group.

Listed below is the documentation required for a 2-50 sold case submission. UnitedHealthcare reserves the right to request additional supporting documentaton for any submission. Incomplete items may cause delays. To submit a 2-50 sold case for installation, please submit the following documentation to [westsub@uhc.com](mailto:westsub@uhc.com).

- Completed [UnitedHealthcare Employer Application for 1–50 business Non-HMO](#) or [HMO](#), including employer & broker signatures.
- UnitedHealthcare’s New Business Enrollment Spreadsheet or completed [employee applications Non-HMO](#) or [HMO](#). Spreadsheets and applications must include Social Security numbers (SSN) for all individuals applying. An [SSN Attestation Form](#) is required if an SSN is not available (or the employee is unwilling to provide), and must be signed by the individual applying. Plan codes must be supplied for each product onto which the employee is enrolling - either on the spreadsheet or on each application.
- [Product Selection Form \(NM013 or NM014\)](#) reflecting all plans sold even if some plans have no enrollment.
- Quote with sold rates. If final enrollment differs from the enrollment reflected on the sold quote, rates or monthly premium will change.
- Copy of binder check payable to UnitedHealthcare, or the [UnitedHealthcare Direct Debit Form](#). Please include the group’s Tax ID number in the memo section of the check. Micro groups (groups with less than 3 eligible employees) submitted through SAM are required to utilize EFT/direct debit as their payment option. UnitedHealthcare cannot accept an alternate form of payment for these groups. For all other new business sales, **live binder checks** should be submitted using the [Prime Binder Check Coversheet](#). All subsequent monthly premium payments should be sent to the address shown on the group's remittance stub.
- Financial documentation - refer to the [NM Tax Documentation Guidelines](#) for groups with 2–9 eligible employees. Groups with 10–50 eligible employees only require a [Participation Certification Form](#) (instead of financial documentation).
- For groups with 1099 employees, the completed [Common Law Employee \(1099\)](#) and [Fact Attestation Form](#) must list all 1099/Independent Contractors. Also required is a written contract or agreement between the employer and the 1099/Independent Contractor, the most recent 12 weeks of payment records (showing hourly/weekly/salaried with paid vacation and sick days, expense reimbursement, records, evidence of pension, other insurance and employee benefits), and an IRS Form SS-8 if applicable. Please refer to the [NM Tax Documentation Guidelines](#) for further information.
- Groups with common ownership must complete and submit the [Common Ownership Form](#).
- Groups utilizing the services of a PEO must complete and submit the [PEO Attestation Form](#).
- To cover commissioned employees, the employer must complete the [Commissioned Employees Form](#) if the commissioned employees are not indicated on a wage and tax statement or acceptable payroll. A year-to-date payroll ledger showing earnings for the commissioned employees must be submitted, if available.

### HELPFUL INFORMATION AND TOOLS

- Participation minimum is 25% of full-time Eligible Employees (waiver forms not required).
- Employee Coverage Contribution of 50% or \$100 Defined Contribution is required.
- Unlimited Medical Multi-Plan Package.
- Attachments (click on the hyperlink in blue to automatically open the document):
 

○ <a href="#">2-50 Product Grid NM013</a>	○ <a href="#">NM Tax Documentation Guidelines</a>	○ <a href="#">UHC NM Employee App Non-HMO</a>
○ <a href="#">2-50 Product Grid NM014</a>	○ <a href="#">Participation Certification</a>	○ <a href="#">UHC NM Employee App HMO</a>
○ <a href="#">Commissioned EEs</a>	○ <a href="#">PEO Attestation</a>	○ <a href="#">UHC NM Employer App Non-HMO</a>
○ <a href="#">Common Law EE/1099</a>	○ <a href="#">Prime Binder Check Coversheet</a>	○ <a href="#">UHC NM Employer App HMO</a>
○ <a href="#">Common Ownership</a>	○ <a href="#">Product Selection Form NM013</a>	
○ <a href="#">Direct Debit Form</a>	○ <a href="#">Product Selection Form NM014</a>	
○ <a href="#">How to Pull SBCs</a>	○ <a href="#">SSN Attestation</a>	

NOTICE: Deductible and out-of-pocket credit is available for employees and dependents who were enrolled under the group health plan being replaced by UnitedHealthcare. A prior carrier report should be submitted to your UnitedHealthcare representative within 90 days of the group’s effective date.

### Not For Consumer Use.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.  
Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through UnitedHealthcare of New Mexico, Inc.