

Employer Application for Small Business



New York

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

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

Medical Benefit Plan Option Calendar Year Policy Year

Domestic Partner Coverage Yes No

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 _____	Other	Other	Other		

Coverage provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by UnitedHealthcare Insurance Company of New York
 Dental coverage provided by UnitedHealthcare Insurance Company of New York
 Vision coverage provided by UnitedHealthcare Insurance Company of New York

General Information (continued)

Yes **Subject to ERISA? (Most private sector plans are ERISA plans)**
 No 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
 UnitedHealthcare recommends that the same HRA designs are followed even if using an external HRA administrator. You are not required to use UnitedHealthcare for HRA administration.

Comprehensive supplemental insurance policy or funding arrangement Yes No

If you answered “Yes” to either question above, we will recommend a list of medical plans that will be presented for you to choose from, as shown to you by your broker or agent, however you are free to choose a plan that best suits your needs. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

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

Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> 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.
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> 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 <input style="width: 80px; height: 30px;" type="text"/>	Under state 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 _____

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 of material fact, fraudulent statement, or omission that constitutes fraud may result in termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

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.

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature

Group Authorized Signature	Title	Date
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Producer Information (if applicable)

Writing Producer Name	Writing Producer SSN	Is the Producer appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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*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