

SERFF Tracking Number: UHLC-126787407 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company of the River Valley State Tracking Number: 46619
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 Enrollment Forms
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare Insurance Company of the River Valley

Product Name: 2010 Enrollment Forms

SERFF Tr Num: UHLC-126787407 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 46619

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Author: Ebony Terry

Reviewer(s): Rosalind Minor

Date Submitted: 08/26/2010

Disposition Date: 10/25/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/25/2010

Explanation for Other Group Market Type:

State Status Changed: 10/25/2010

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Filing Description:

2010 Enrollment Forms

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony_N_Terry@uhc.com

800 King Farm Blvd.

240-632-8053 [Phone]

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Suite 500
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare Insurance Company of the River Valley 1300 River Drive, Suite 200 Moline, IL 61265 (309) 765-1485 ext. [Phone]	CoCode: 12231 Group Code: 707 Group Name: FEIN Number: 20-1902768	State of Domicile: Illinois Company Type: Health State ID Number:
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Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	2 Forms X 50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company of the River Valley	\$100.00	08/26/2010	39034702

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/25/2010	10/25/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/02/2010	09/02/2010	Ebony Terry	10/17/2010	10/17/2010

SERFF Tracking Number: UHLC-126787407 *State:* Arkansas
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Disposition

Disposition Date: 10/25/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Cover Letter and Previously Approved Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

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TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 Enrollment Forms
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/02/2010
Submitted Date 09/02/2010

Respond By Date

Dear Ebony Terry,

This will acknowledge receipt of the captioned filing.

Objection 1

- Enrollment Form, 100-9866 8/10 (Form)

Comment:

Will this form ever be used as a stand alone form? If so, it must contain a Fraud Statement.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/17/2010
 Submitted Date 10/17/2010

Dear Rosalind Minor,

Comments:

Please see attached cover for the resubmission on the following revised form # SB.ER.10.AR 06/10

Response 1

Comments: It will never be issued as a stand alone form.

Related Objection 1

Applies To:

- Enrollment Form, 100-9866 8/10 (Form)

Comment:

Will this form ever be used as a stand alone form? If so, it must contain a Fraud Statement.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Cover Letter and Previously Approved Form

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Enrollment Form	SB.ER.10. AR 06/10		Application/Enrollment Form	Revised	SB.ER.10. AR 06/10		SB ER 10 AR 6 10 (revised).pdf

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No Rate/Rule Schedule items changed.

Sincerely,
Ebony Terry

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/25/2010	750-0045 8/10	Application/ Enrollment Form	Initial			750-0045 RV INS SB R_R broch 8 10.pdf
Approved-Closed 10/25/2010	100-9866 8/10	Application/ Enrollment Form	Initial			100-9866 health adden 10 8.12.10.pdf
Approved-Closed 10/25/2010	SB.ER.10. AR 06/10	Application/ Enrollment Form	Revised	Replaced Form #: SB.ER.10.AR 06/10 Previous Filing #: SB.ER.10.AR 06/10		SB ER 10 AR 6 10 (revised).pdf

By completing your enrollment form:

- You authorize all providers of health services or supplies and any of their representatives to give the following to UnitedHealthcare: any available information about the medical history, condition or treatment of any person named in the request. You authorize UnitedHealthcare to use the information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.
- You also authorize UnitedHealthcare to give the information to its (their) representatives or to any other organization for the reason noted above. You agree that the authorization is valid for 30 months from the date of the enrollment form. You have the right to ask for and receive a copy of the authorization.
- You understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding your coverage may be transmitted electronically.
- You have not given the agent or any other persons any health information not included on the enrollment form. You understand that UnitedHealthcare is not bound by any statements you have made to any agent or to any other persons, if those statements are not written or printed on the enrollment form and any attachments.
- You have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after you sign the enrollment form and before receipt of your identification card.

Confidentiality

Make sure your employer has completed the “To be completed by the employer” section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



Your rights and responsibilities



Insurance coverage provided by or through UnitedHealthcare Insurance Company of the River Valley

750-0045 8/10 ©2010 United HealthCare Services, Inc.



Important information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete, and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at uhcrivervalley.com.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Preexisting conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a preexisting condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a preexisting condition exists. A group health plan may exclude benefits for preexisting conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a preexisting condition. A preexisting condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a preexisting condition unless there is a specific diagnosis related to the information.

Any references to Preexisting Conditions do not apply to anyone under the age of 19 whose plan is subject to insurance reforms contained in the Affordable Care Act.

Under federal law, a group health plan must reduce a preexisting condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a preexisting condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any preexisting condition exclusion), you must show proof of prior coverage. You have the right to request a certificate of creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information. If you have questions regarding the preexisting condition limitation or certificate of creditable coverage, please contact Customer Care at 1-800-350-7584.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

When completing a joint life and health enrollment form, you must understand that each response must be complete and accurate.

You request the indicated group medical and/or life coverages for yourself and, if the plan provides, for your dependents.

You authorize any required premium contributions to be deducted from earnings.

Group Name: _____

Medical Profile (only for groups not requiring individual health statements)

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information. **Please provide details to "Yes" answers in the space provided.**
IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have any employees or dependents been diagnosed or treated during the past five years for: <table style="width: 100%; margin-left: 20px;"> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Immune Disorder</td> <td><input type="checkbox"/> Growth Hormones</td> </tr> <tr> <td><input type="checkbox"/> Tumor</td> <td><input type="checkbox"/> AIDS/HIV+</td> <td><input type="checkbox"/> Transplants</td> </tr> <tr> <td><input type="checkbox"/> Heart/Circulatory</td> <td><input type="checkbox"/> Chronic Lung Disorder</td> <td><input type="checkbox"/> Hemophilia/Blood Disorders</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Kidney Disease/Failure</td> <td><input type="checkbox"/> Cerebral Palsy</td> </tr> <tr> <td><input type="checkbox"/> Reproductive Disorder</td> <td><input type="checkbox"/> Liver Disorders (Hepatitis)</td> <td><input type="checkbox"/> Sickle cell anemia</td> </tr> <tr> <td><input type="checkbox"/> Intestinal Disorder</td> <td><input type="checkbox"/> Back Disorder</td> <td><input type="checkbox"/> Immuno deficiency</td> </tr> <tr> <td><input type="checkbox"/> Endocrine Disorder</td> <td><input type="checkbox"/> Rheumatoid Arthritis</td> <td><input type="checkbox"/> Autism</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Connective Tissue Disorder</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Brain/Nervous/Seizures</td> <td><input type="checkbox"/> Lupus</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Multiple Sclerosis</td> <td><input type="checkbox"/> Other Conditions _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Cancer	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Growth Hormones	<input type="checkbox"/> Tumor	<input type="checkbox"/> AIDS/HIV+	<input type="checkbox"/> Transplants	<input type="checkbox"/> Heart/Circulatory	<input type="checkbox"/> Chronic Lung Disorder	<input type="checkbox"/> Hemophilia/Blood Disorders	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease/Failure	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Reproductive Disorder	<input type="checkbox"/> Liver Disorders (Hepatitis)	<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> Back Disorder	<input type="checkbox"/> Immuno deficiency	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Autism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Connective Tissue Disorder		<input type="checkbox"/> Brain/Nervous/Seizures	<input type="checkbox"/> Lupus		<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other Conditions _____	
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<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other Conditions _____																														
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section.																														
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years?																														
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?																														
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?																														
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare?																														

If you answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, continue your comments on the back side of this form.

Question #	Check One Emp	Check One Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	\$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by UnitedHealthcare Insurance Company and its Affiliates ("UnitedHealthcare and Affiliates").

The Group shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent, including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

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 misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy effective date, or other consequences.

Signature		
Group Signature	Title	Date

Employer Application for Small Business

BAR CODE HERE

[Groups with 2-99 Eligible Employees]

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)

Contact Person

Telephone

Fax

Email Address

Billing Address (If Different)

of Years in Business

Organization Type Partnership C-Corp S-Corp LLC/LLP

Nature of Business

Industry (SIC) Code

Ind. Contractor Sole Proprietor Other _____

Multi-Location Group* Yes No

Locations

Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.

Subject to ERISA regulation

Yes No

Waiting Period for new hires

- 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

Medical Benefit Plan Option

- Calendar Year
- Policy Year

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

Classes Excluded: None Union Hourly Non-Management Non-Owners

By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation	# Employees Applying for:	# Employees Waiving for:	Contribution	Employer %	Employer % for Dep
# Eligible Employees working in AR _____	Medical	Medical	Medical		
	Dental	Dental	Dental		
# Eligible Employees working outside AR _____	Vision	Vision	Vision		
	Basic Life/AD&D	Basic Life/AD&D	Basic Life/AD&D		
# Ineligible Employees _____	Dep Life	Dep Life	Dep Life		
	Supp Life/AD&D	Supp Life/AD&D	Supp Life/AD&D		
Total # Employees <input type="text"/>	Dep Supp Life/AD&D	Dep Supp Life/AD&D	Dep Supp Life/AD&D		
	STD	STD	STD		
# Hours per week to be eligible** _____	STD Buy Up	STD Buy Up	STD Buy Up		
	LTD	LTD	LTD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.	LTD Buy Up	LTD Buy Up	LTD Buy Up		
	Other	Other	Other		

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.

Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company [or Unimerica Life Insurance Company of New York]

Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

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 Definity 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 Definity 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.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy following a leave of absence? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

- Last Day worked (following the last day worked for the minimum hours required to be eligible)
- 3 Months (following the last day worked for the minimum hours required to be eligible)
- 6 Months (following the last day worked for the minimum hours required to be eligible)
- UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

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

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	Coverage Begin Date	Coverage End Date
Current Medical Carrier	<input type="checkbox"/> None			
Current Dental Carrier	<input type="checkbox"/> None			
Current Vision Carrier	<input type="checkbox"/> None			
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			

Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> St. 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.
<input type="checkbox"/> Federally Compliant MH/SUD Benefits <input type="checkbox"/> Not Required	Under federal law, if your group averaged 51 or more total employees (remember to include part-time and seasonal employees) during the preceding calendar year, you must provide employees with benefits compliant with federal mental health and substance use disorder parity laws and regulations (MH/SUD Parity Compliant Benefits), if your plan provides MH/SUD benefits. If your group had 50 or fewer employees, you are not required to provide MH/SUD Parity Compliant Benefits.
<input type="checkbox"/> Yes <input type="checkbox"/> 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) of 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.

Questions Regarding Group Size (continued)

- Yes
 No
- Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

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.

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 misrepresentation 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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

UnitedHealthcare disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed 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. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. 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 is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers pursuant to federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to <http://www.uhc.com> and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date
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Commission Information

Writing Broker Name	Writing Broker SSN	Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker 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.

Broker Signature

Date

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

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

Admin Kit

Send Admin Kit To:	Address
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[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.]

SERFF Tracking Number: UHLC-126787407 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company of the State Tracking Number: 46619
 River Valley
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2010 Enrollment Forms
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	10/25/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/25/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	10/25/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/25/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/25/2010
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number: UHLC-126787407 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company of the State Tracking Number: 46619
 River Valley
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2010 Enrollment Forms
 Project Name/Number: /

		Item Status:	Status
			Date:
Satisfied - Item:	Cover Letter	Approved-Closed	10/25/2010
Comments:			
Attachment:			
	2010 Enrollment Form cover Letter _River Valley_Revisions_.pdf		

		Item Status:	Status
			Date:
Satisfied - Item:	Cover Letter and Previously Approved Form	Approved-Closed	10/25/2010
Comments:			
Attachments:			
	2010 Enrollment Form cover Letter _Revisions_ 10.15.2010.pdf		
	SB ER 10 AR 6 10.pdf		



August 25, 2010

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: [UnitedHealthcare Insurance Company of the River Valley 12231](#)

Dear Ms. Minor,

On behalf of [UnitedHealthcare Insurance Company of the River Valley](#), I am submitting the enclosed replacement enrollment/application forms for your Department's review and approval. [A listing and description of the forms, along with the Flesch Scores, has been provided below for your reference.](#)

<u>Form Number</u>	<u>Description</u>	<u>Flesch Score</u>
750-0045 8/10	Rights and Responsibilities Brochure	43.5
100-7381 6/10	Health Addendum	41.1

These forms are our standard forms and have been prepared for use in your state for group sizes 2-99 for medical, dental, vision and ancillary products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

The revisions to these replacement forms are clerical for the most part but if you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

[Ebony N. Terry](#)
Compliance Analyst



October 15, 2010

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: [UnitedHealthcare Insurance Company
NAIC No. 79413
Unimerica Insurance Company
NAIC No. 91529]
[95446 United Healthcare of Arkansas, Inc.®]
[UnitedHealthcare Insurance Company of the River Valley
NAIC No. 12231]

Enrollment/Application Filings

Dear Ms. Minor,

On behalf of [UnitedHealthcare Insurance Company] [Unimerica Insurance Company] [United Healthcare of Arkansas, Inc.®][UnitedHealthcare Insurance Company of the River Valley] I am submitting the enclosed replacement enrollment/application form for your Department's review and approval. A listing and description of the forms, along with the Flesch Scores, has been provided below for your reference.

<u>Form Number</u>	<u>Description</u>	<u>Flesch Score</u>
SB.ER.10.AR 06/10	Employer Application for Small Business	43.5

This form is one of our standard forms and has been prepared for use in your state for group sizes 2-99 for medical, dental, vision and ancillary products. Information contained within this form may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

The revisions to this replacement form were made to the Participation section and the previously approved form has been provided so that you may compare the two. If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Ebony N. Terry
Compliance Analyst

Employer Application for Small Business

[Groups with 2-99 Eligible Employees]

BAR CODE HERE

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)

Contact Person

Telephone

Fax

Email Address

Billing Address (If Different)

of Years in Business

Organization Type Partnership C-Corp S-Corp LLC/LLP

Nature of Business

Industry (SIC) Code

Ind. Contractor Sole Proprietor Other _____

Multi-Location Group* Yes No

Locations

Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.

Subject to ERISA regulation

Yes No

Waiting Period for new hires

- 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

Medical Benefit Plan Option

- Calendar Year
- Policy Year

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

Classes Excluded: None Union Hourly Non-Management Non-Owners

By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

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			
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D			
		Dep Life		Dep Life		Dep Life			
# Hours per week to be eligible**		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D			
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D			
		STD		STD		STD			
		STD Buy Up		STD Buy Up		STD Buy Up			
		LTD		LTD		LTD			
		LTD Buy Up		LTD Buy Up		LTD Buy Up			
		Other		Other		Other			

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company or UnitedHealthcare Insurance Company of the River Valley or United HealthCare of Arkansas, Inc.
 Dental coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company [or Unimerica Life Insurance Company of New York]
 Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

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 Definity 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 Definity 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.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy following a leave of absence? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

- Last Day worked (following the last day worked for the minimum hours required to be eligible)
- 3 Months (following the last day worked for the minimum hours required to be eligible)
- 6 Months (following the last day worked for the minimum hours required to be eligible)
- UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

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

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	Coverage Begin Date	Coverage End Date
Current Medical Carrier	<input type="checkbox"/> None			
Current Dental Carrier	<input type="checkbox"/> None			
Current Vision Carrier	<input type="checkbox"/> None			
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			

Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> St. 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.
<input type="checkbox"/> Federally Compliant MH/SUD Benefits <input type="checkbox"/> Not Required	Under federal law, if your group averaged 51 or more total employees (remember to include part-time and seasonal employees) during the preceding calendar year, you must provide employees with benefits compliant with federal mental health and substance use disorder parity laws and regulations (MH/SUD Parity Compliant Benefits), if your plan provides MH/SUD benefits. If your group had 50 or fewer employees, you are not required to provide MH/SUD Parity Compliant Benefits.
<input type="checkbox"/> Yes <input type="checkbox"/> 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) of 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.

Questions Regarding Group Size (continued)

- Yes
 No
- Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

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.

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 misrepresentation 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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers pursuant to federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to <http://www.uhc.com> and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date
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Commission Information

Writing Broker Name	Writing Broker SSN	Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker 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.

Broker Signature

Date

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

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

Admin Kit

Send Admin Kit To:	Address
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[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.]