

SERFF Tracking Number: UHLC-126863784 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 47067
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 AR Enrollment Form Revision
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: 2010 AR Enrollment Form SERFF Tr Num: UHLC-126863784 State: Arkansas

Revision

TOI: H21 Health - Other

SERFF Status: Closed-Approved- State Tr Num: 47067
Closed

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Ebony Terry

Disposition Date: 11/01/2010

Date Submitted: 10/16/2010

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:

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/01/2010

Explanation for Other Group Market Type:

State Status Changed: 11/01/2010

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Filing Description:

2010 AR Enrollment Form Revision

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony_N_Terry@uhc.com

800 King Farm Blvd.

240-632-8053 [Phone]

SERFF Tracking Number: UHLC-126863784 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 47067
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2010 AR Enrollment Form Revision
 Project Name/Number: /

Suite 500
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300	Group Name:	State ID Number:
Little Rock, AK 72205	FEIN Number: 63-1036819	
(952) 992-7428 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	10/16/2010	40829362

SERFF Tracking Number: UHLC-126863784 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 47067
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 AR Enrollment Form Revision
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/01/2010	11/01/2010

SERFF Tracking Number: UHLC-126863784 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 47067
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 AR Enrollment Form Revision
Project Name/Number: /

Disposition

Disposition Date: 11/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-126863784

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 47067

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: 2010 AR Enrollment Form Revision

Project Name/Number: /

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	Approved Form	Approved-Closed	Yes
Form	Small Business Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: UHLC-126863784

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 47067

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: 2010 AR Enrollment Form Revision

Project Name/Number: /

Form Schedule

Lead Form Number: SB.ER.10.AR 06/10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 11/01/2010	SB.ER.10. AR 06/10	Application/ Enrollment Form	Small Business 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

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
----------------------------	-------	------

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
--------------------	---------

[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-126863784
Filing Company: UnitedHealthcare of Arkansas, Inc.
Company Tracking Number:
TOI: H21 Health - Other
Product Name: 2010 AR Enrollment Form Revision
Project Name/Number: /

State: Arkansas
State Tracking Number: 47067
Sub-TOI: H21.000 Health - Other

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	11/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	11/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/01/2010
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number: UHLC-126863784 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 47067
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 AR Enrollment Form Revision
Project Name/Number: /

Item Status: Approved-Closed
Status Date: 11/01/2010
Satisfied - Item: Cover Letter
Comments:
Attachment:
2010 Enrollment Form cover Letter _Revisions_ 10.15.2010.pdf

Item Status: Approved-Closed
Status Date: 11/01/2010
Satisfied - Item: Approved Form
Comments:
Attachment:
SB ER 10 AR 6 10.pdf



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

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		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.

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
----------------------------	-------	------

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
--------------------	---------

[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.]