

SERFF Tracking Number: UHLC-126061001 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 45135
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Enrollment Application
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: Enrollment Application

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-126061001 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 45135

Co Tr Num:

Author: Ebony Terry

Date Submitted: 03/07/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 03/10/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/10/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/10/2010

Created By: Ebony Terry

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Ebony Terry

Filing Description:

Small Business Enrollment Application

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

4 Taft Court

Rockville, MD 20850

Ebony_N_Terry@uhc.com

301-838-5611 [Phone]

301-838-5676 [FAX]

Filing Company Information

<i>SERFF Tracking Number:</i>	<i>UHLC-126061001</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare of Arkansas, Inc.</i>	<i>State Tracking Number:</i>	<i>45135</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Erollment Application</i>		
<i>Project Name/Number:</i>	<i>/</i>		
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:	\$400.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$400.00	03/07/2010	34664268

SERFF Tracking Number: UHLC-126061001

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/10/2010	03/10/2010

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Disposition

Disposition Date: 03/10/2010

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	Cover Letter	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment 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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Form Schedule

Lead Form Number: SB.ER.09.AR 2/09

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 03/10/2010	SB.ER.09. AR 02/09	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-3606 AR SB ER 09 RV.pdf
Approved- Closed 03/10/2010	262-3607 2/10	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-3607 AR health adden 10.pdf
Approved- Closed 03/10/2010	SB.EESHT. 07.AR	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-3609 AR EE sht 07 qxp.pdf
Approved- Closed 03/10/2010	SB.EELNG. 07.AR	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-3610 AR EE long 07 qxp.pdf
Approved- Closed 03/10/2010	SB.EEONE Q.07.AR	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-3611 AR 1-Q 07.pdf
Approved- Closed 03/10/2010	LG.ER.10. AR 2/10	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-4583 LG ER 10 AR app.pdf
Approved- Closed 03/10/2010	LG.EE.07.A R 10/07	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262-4584 AR LG EE sht app 07 qxp.pdf
Approved- Closed 03/10/2010	SB.EE.07.A R 10/07	Application/ Enrollment Form	Application/ Enrollment Form	Initial			262 -3608 AR-EE..pdf

Employer Application for Small Business



[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.

- UnitedHealthcare Insurance Company
- United HealthCare of Arkansas, Inc.
- UnitedHealthcare Insurance Company of the River Valley
- Unimerica Insurance Company

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

Participation	# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
	Medical	Dental	Medical	Dental			
# Eligible Employees working in AR _____					Medical		
# Eligible Employees working outside AR _____					Dental		
Total # Employees 	Vision		Vision		Vision		
	Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
# Hours per week to be eligible** _____	Dep Life		Dep Life		Dep Life		
	Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.	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 UnitedHealthcare Insurance Company, United HealthCare of Arkansas, Inc, or UnitedHealthcare Insurance Company of the River Valley

Dental coverage provided by UnitedHealthcare Insurance Company [or United HealthCare of XXX] or Unimerica Insurance Company

Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

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 (including, but not limited to termination 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*
- Other (please provide a copy for our records)

***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 of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
<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"/> Yes <input type="checkbox"/> 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.
<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.

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
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*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.]

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). 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, 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%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Cancer</td> <td style="width: 33%;"><input type="checkbox"/> Immune Disorder</td> <td style="width: 33%;"><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 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 United HealthCare 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.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature	Title	Date	
Group Signature			

D. Prior Medical Insurance Information**This section must be completed to receive credit for prior medical coverage.**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

 NO YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: Employee Spouse Child(ren) Family**E. Other Medical Coverage Information****This section must be completed. (Attach sheet if necessary.)**On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at workAre you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date ___/___/___

Medicare – Spouse/Dependent Name: _____

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form.

Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.** Yes No 1. Is anyone on this application currently pregnant? If "yes" please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section. Yes No 2. Has anyone on this application visited any health care professional during the last 10 years for any illness, injury, or health condition? If your answer is "yes" please provide detailed information on next page for each person involved. Yes No 3. Has anyone on this application been hospitalized (inpatient or outpatient) or had surgery in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved. Yes No 4. Has anyone on this application been prescribed or taken any prescription medications in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved. Yes No 5. Does anyone on this application have a health condition, illness, or injury that may require treatment or surgery, or has any health care professional recommended treatment or surgery for any of you that has not been performed? If your answer to either question is "yes" please provide detailed information below for each person involved.**Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)**

(continued on the next page)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

G. Waiver of Coverage		Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Other _____	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.
I decline all coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents			
Date	Employee Signature if waiving coverage		

H. Signature		
<p>I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.</p> <p>I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.</p> <p>A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>		
Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

I. Census Information (optional)			
NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.			
1. Race, check all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black, African-American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other Race, please specify _____			
2. Are you of Hispanic or Latino origin? <input type="checkbox"/> Yes <input type="checkbox"/> No			

D. Prior Medical Insurance Information**This section must be completed to receive credit for prior medical coverage.**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

 NO YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: Employee Spouse Child(ren) Family**E. Other Medical Coverage Information****This section must be completed. (Attach sheet if necessary.)**On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at workAre you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date ___/___/___

Medicare – Spouse/Dependent Name: _____

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Medical History

Employee Name _____ SSN _____ Group Name _____

Has anyone on this application consulted with or been examined or treated by any health care professional during the last 10 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.**

1 Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____ <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate Stage _____
2 Heart/Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Other _____
3 Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date _____) <input type="checkbox"/> Multiples (# _____) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Fibroids <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
4 Intestinal/Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other _____
5 Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Tumor <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Other _____
6 Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Immuno Deficiency <input type="checkbox"/> Other _____
7 Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____
8 Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____

(continued on next page)

F. Medical History (continued)

9 Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
10 Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/CFS <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other _____
11 Behavioral Health <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpat ETOH/Drug <input type="checkbox"/> Inpat MH Hosp <input type="checkbox"/> Other _____
12 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications Year _____ <input type="checkbox"/> Other _____
13 Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications Please List Meds _____ <input type="checkbox"/> Medications Taken Within The Past Year Please List Meds _____
14 Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised <input type="checkbox"/> Pending Test Results <input type="checkbox"/> Inpat Hosp/Surg in Past Yr. <input type="checkbox"/> Pending w/c claim <input type="checkbox"/> Tests Advised or Recommended <input type="checkbox"/> Refer to Specialist <input type="checkbox"/> Disability

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

G. Waiver of Coverage I decline all coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents	Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Other _____	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.
	Date	Employee Signature if waiving coverage

H. Signature I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
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I. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: White Black, African-American American Indian/Alaska Native Asian
 Native Hawaiian/Pacific Islander Other Race, please specify _____

2. Are you of Hispanic or Latino origin? Yes No

D. Prior Medical Insurance Information**This section must be completed to receive credit for prior medical coverage.**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

 NO YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: Employee Spouse Child(ren) Family**E. Other Medical Coverage Information****This section must be completed. (Attach sheet if necessary.)**On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at workAre you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date ___/___/___

Medicare – Spouse/Dependent Name: _____

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Medical History

Employee Name _____ SSN _____ Group Name _____

Please answer the following questions for yourself and each person listed in Section B "Family Information" on the first page of this form.

Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.** Yes No In the last 10 years have you or any member of your family listed on this application been treated for a serious illness?

Examples include, but are not limited to any of the following: cancer, diabetes, multiple sclerosis, HIV/AIDS, mental/nervous disorders, congenital birth defects, organ or other transplants, hemophilia, diseases of the liver, kidney, lungs, heart/circulatory system; or has anyone had surgery or incurred medical/pharmacy claims in excess of \$5,000 or is anyone currently pregnant?

If yes, please provide details on next page.**Please give details to any "yes" answer above.****(If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)**

Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

Insured Employer Application



To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

- UnitedHealthcare Insurance Company
- United HealthCare of Arkansas, Inc.
- UnitedHealthcare Insurance Company of the River Valley
- Unimerica Insurance Company

General Information

Requested Effective Date _____

Group's/Company's Legal Name _____

Street Address _____ Tax ID _____

City _____ State _____ Zip Code _____ County _____

Contact Person _____ Telephone _____ Fax _____ Email Address _____

Billing Address (if different) _____ # of Years in Business _____

Multi-location group/company? Yes No # of Locations _____ Address (es) (or list on additional sheet of paper) _____

Organization Type Partnership C-Corp S-Corp LLC/LLP Nature of Business _____ Industry Code _____
 Ind. Contractor Sole Proprietor Other _____

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
 Other _____

Waiting Period waived for initial enrollees Yes No

Medical Benefit Plan Option Calendar Year Policy Year

ERISA Plan? Yes No

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents) _____ Number of Employees Termed in last 12 Months _____ Classes Excluded: None Union Hourly Non-Management Non-Owners

Name of Workers' Compensation Carrier _____ Names of Owners/Partners not covered by Workers' Compensation _____

Participation	# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
	Medical	Dental	Medical	Dental			
# Eligible Employees					Medical		
# Ineligible Employees					Dental		
Total # Employees					Vision		
					Basic EE Life/AD&D		
					Basic Dep Life		
# Hours per week to be eligible** _____					Supp EE Life/AD&D		
					Supp Dep Life/AD&D		
					STD		
					STD Buy Up		
					LTD		
					LTD Buy Up		
					Other		

Coverage provided by "UnitedHealthcare and Affiliates":

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

Dental coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

- Yes No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
- Yes No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
- Yes No Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) 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.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy (including, but not limited to termination 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*
- Other (please provide a copy for our records)

***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.

HRA, HSA, Supplemental Insurance Information

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.

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? Yes No

Who will provide account balances to UnitedHealthcare?

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 Life Carrier	<input type="checkbox"/> None			
Current Short-Term Disability Carrier	<input type="checkbox"/> None			
Current Long-Term Disability Carrier	<input type="checkbox"/> None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents 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, 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.

- Yes No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?
- Yes No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?
- Yes No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?
- Yes No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?
- Yes No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?
- Yes No 6. Is any employee or dependent currently hospitalized?
- Yes No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?
 - Cancer (any type)
 - Hepatitis
 - Lung disease or respiratory problem (any type)
 - Morbid obesity
 - Heart disease or disorder (any type)
 - Congenital abnormality
 - Organ, tissue or cell transplant
 - Vascular disease (any type)
 - Liver disease (any type)
 - Neurological disorder (any type)
 - Kidney disease (any type)
 - Immunological disorder (reportable types)
 - Pancreatic disorder (any type)
 - Alcohol or drug addiction or abuse
 - Diabetes

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check One Employee	Check One Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	\$ Amount of Claims	Current Treatment

State Mandated Offers

Arkansas statutes require the optional coverage listed below to be offered to each group. The group can separately accept or reject the "mandated offer". Your Broker or agent can provide you with additional information, including any additional premium amount required for the mandated offer. Please note that not all mandated offers are listed below; some mandated offers are standardly included in UnitedHealthcare plans.

Please use the checkboxes below to indicate your acceptance or rejection of the "mandated offer".

- Accept
 Reject
- Optional coverage for musculoskeletal disorders of the face, neck or head, as described by Arkansas Statute 23-79-150

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company 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/Company 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 to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Group's/Company's employees.

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

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/company 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 as required by applicable 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 click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature _____ Date _____ Title _____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

Broker Name		Agency		Agent Code/Tax ID Number	
Signature	Email Address	Social Security #	Phone Number	Date	
Rep Name			Rep #		
Commissions payable to		Broker Commission Schedule _____ Std Scale of _____ %			

Enrollment Application/Change/Cancellation Request



- UnitedHealthcare Insurance Company
- United HealthCare of Arkansas, Inc.
- UnitedHealthcare Insurance Company of the River Valley
- Unimerica Insurance Company

- Enroll**
- Cancel**
- Change**
- Address Change**
- Name Change**
- Date of Change** ___/___/___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name _____		Group # _____	Department # _____
Plan Variation		Reporting Code	Benefit Level/Class Code, if applicable
Medical _____	Vision _____	Medical _____	Vision _____
Dental _____	Life _____	Dental _____	Life _____
			Life/AD&D _____
			Spouse Life _____
			Suppl. Life _____
			Suppl. AD&D _____

<input type="checkbox"/> New Enrollment/Additions: (Check one) Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Court ordered dependent <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/State Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___/___/___	<input type="checkbox"/> Cancellations: Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel all listed below – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____
--	--

Employee Type Union Non-union Salaried Hourly Active Retire Date _____ COBRA/State Cont.

Signature _____ Date _____

A. Employee Information

Employer Position _____ Phone Number _____

Last Name _____		First Name _____	MI _____	Social Security Number _____	Home Phone _____
Address _____		Apt # _____	City _____	State _____	Zip Code _____
Date of Birth ___/___/___	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Physician* (First & Last Name) / Physician's ID Number _____		Primary Care Dentist Number* _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Race – Check all that apply (Optional)** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____			

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by UnitedHealthcare Insurance Company, United HealthCare of Arkansas, Inc. or UnitedHealthcare Insurance Company of the River Valley
 Dental coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
 Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
 Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Canceling (Attach sheet if necessary)

Check appropriate box	Last Name	First Name	MI	Sex	Relationship**	Birthdate	Full Time Student***	Physician* (First and Last Name) Physician's ID Number
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change				M F	Spouse			
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Primary Care Dentist Number*
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Primary Care Dentist Number*
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Primary Care Dentist Number*
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change				M F	Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race – Check all that apply (Optional)**** <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____								Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.
 ** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.
 *** Please see employer representative for student status qualifications.
 **** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address	Relationship
--	--------------

D. Other Medical Coverage Information This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
 S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
 F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.
 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

Medicare – Spouse/Dependent Name: _____
 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage	I decline coverage for:	Declining coverage due to existence of other coverage:	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I acknowledge that I have received the "Important Information" statement which is included with this form.
	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents		

F. Signature I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)
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Primary Language Spoken English Spanish Other _____

IMPORTANT INFORMATION

In order to make choices about your health care 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, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care 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 provider 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 may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. 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.
5. 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 provider's treatment or plan.
6. 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 with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

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

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

D. Prior Medical Insurance Information**This section must be completed to receive credit for prior medical coverage.**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

 NO YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: Employee Spouse Child(ren) Family**E. Other Medical Coverage Information****This section must be completed. (Attach sheet if necessary.)**On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at workAre you receiving Social Security Disability Insurance (SSDI)? YES NO Start Date ___/___/___

Medicare – Spouse/Dependent Name: _____

 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)** Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)** Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)**Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Waiver of Coverage

I decline all coverage for:

- Myself
 Spouse
 Dependent Children
 Myself and all dependents

Declining coverage due to existence of other coverage:

- Spouse's Employer's Plan Individual Plan
 Covered by Medicare Medicaid
 COBRA from Prior Employer VA Eligibility
 Tri-Care
 I (we) have no other coverage at this time
 Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Date _____ Employee Signature if waiving coverage _____

G. Signature

I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
------	-------------------------------------	---

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: White Black, African-American American Indian/Alaska Native Asian
 Native Hawaiian/Pacific Islander Other Race, please specify _____
2. Are you of Hispanic or Latino origin? Yes No

SERFF Tracking Number: UHLC-126061001

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 45135

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Enrollment Application

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			
Satisfied - Item:	Cover Letter	Approved-Closed	03/10/2010
Comments:			
Attachment:			
UHC AR cover.pdf			

March 07, 2010,

Via U.S. Mail

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

NAIC: 95446 UnitedHealthcare of Arkansas, Inc.

Form # SB.ER.09.AR
262-3607 2/10
SB.EE.07.AR 10/07
SB.EESHT.07.AR 12/07
SB.EEONEQ.07.AR 10/07
LG.ER.10.AR 2/10
LG.EE.07.AR 10/07
SB.EELNG.07.AR 10/07

Dear Ms. Minor,

On behalf of UnitedHealthcare of Arkansas, Inc. please accept this correspondence as a submission of the above referenced Enrollment forms for your review and approval. This submission has been submitted electronically via SERFF and UnitedHealthcare of Arkansas, Inc. recognizes that we may not implement these forms until and unless approval has been granted.

Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 240.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry
Compliance Analyst
Enclosure
ENT