

North Carolina New Business Checklist

51-99 Eligible Employees

Medical		Life/AD&D Prime		Dental	Vision	
1 = Items needed to quote 2 = Additional items needed to Underwrite 3 = Additional items needed to Install		For carve-out's, if no prior carrier or is currently self-funded: **		<=Guarantee Amount	>Guarantee Amount	
1	Completed Request for Proposal Form	✓	✓	✓	✓	
1	Excel Census (emailed)	✓	Gender, DOB or Age, coverage election, EE home zip, status (Cobra, retiree, etc.)		✓	
3	Direct Debit Form or Binder Check	✓	✓	* not required for standalone Life	* not required for standalone Vision	
1	Medical Benefit Options Checklist	✓	✓	* not required for standalone Dental		
2	Ancillary Benefit Options Checklist		✓	✓	✓	
3	Most Recent Medical Billing Statement	✓				
3	Dental Prior Billing Statement	To waive Waiting Period- Dental Statement showing 12 mo. & summary of benefits			✓	
2	Most recent Wage & Tax		✓			
2			Only required for carveout or Virgin Groups			
3	Employer Application (430-3900 11/07)	✓	✓	✓	✓	
	Health Addendum to Employer Application (430-3901)	✓				
2	Enrollment Spreadsheet	✓	✓	✓	✓	
2	Employee Application w/ 1 medical question (430-3905 11/07)**		✓			
3			* Carveout or Self Funded			
3	Employee Application w/14 medical questions (430-3904 11/07)		✓	✓		
3			*Virgin group only			
	Current and Renewal Rates	✓				

* Employee Applications for groups (other than those that do not have a prior carrier or are currently Self-Funded) do not need submitted to obtain a proposal or underwritten rates. An Enrollment Spreadsheet is needed prior to case installation.

** Groups that are submitted as a carve-out, are currently uninsured or are currently Self-Funded must have medical questions answered at the Employee level in order to obtain underwritten rates. A proposal can be issued but not underwritten rates until Employee Applications are submitted. This also applies to groups with current coverage that have less than 50% of their employees listed on the most recent prior billing statement.

UnitedHealthcare of North Carolina, Inc. and UnitedHealthcare Insurance Company, Inc. coverage will only be offered as carrier replacement to current group health coverage.

Contact Information:

Email: NC_SML_BUS_NEW@uhc.com

Fax: 866-838-6779

Phone: Please contact your Sales Operations Specialist or Account Executive directly. If they are unavailable call 866-607-5978.

Address:
UnitedHealthcare- SB Sales Ops
3803 N. Elm Street
Greensboro, NC 27455

2.23.09

NC Broker New Business Workflow (51-99 Life Groups)

**** All Turnaround times are estimated and may change depending upon work volume at different times of the month**

→ Complete Sold Group Packet or Request for Proposal

→ Submit to Greensboro Sales Office
E-Mail: NC_SML_BUS_NEW@UHC.com
Fax: 1-866-838-6779

→ Case assigned to Sales Op Specialist (SOS), and Reviewed for missing information within **48 Hours**

→ Is Case Complete??

- NO

- Case Acknowledgement sent to broker requesting missing information
- Broker gets missing info and sends to SOS

-YES

- Case Acknowledgement sent to broker
- Go to next step

→ SOS sends case to Rating

→ SOS receives Ancillary Quotes, generates preliminary medical rates, then sends to MUW* (3 Days)

***Provided ER app submitted. If no ER app, broker will get Preliminary Rates and case will not be sent to MUW until ER app received.**

→ Underwritten Rate approval received (**3-5 Business Days**) and sent to broker

→ Broker notifies SOS of group's decision

-Sold

- Broker notifies SOS of plan selection
- Sets up enrollment meeting with group

-Not Sold


Submission closed

→ Broker forwards enrollment forms or enrollment spreadsheet to SOS
Enrollment is reviewed by SOS and sent to Case Installation (**48 Hours**)
Reserve Policy # is released within 24 hours of case being sent to Installation.

→ Installation summary and Welcome Letter sent to broker and group by Case Install (**5 Business Days**)

→ Group & member info available the **following business day** thru Customer Service
Members RX Benefits are accessible within **2 Business Days**
Members can register on myuhc.com in **72 Hours**
Members can print temp ID cards **24 Hours after registering on myuhc.com**
Permanent ID cards sent to members and admin kit sent to group in **7-10 Business Days**
Group Policy and member Certificates of Coverage are available online.

51-99 Request for Proposal Form (e-mail to: NC_SML_BUS_New@UHC.com or fax to: 1-866-375-9224)

Grp Name:			
Address:	City	State	Zip
Req. Eff Date:	Current Renewal Date:		
SIC Code:	Description of Business:		
Current Carrier:	How long?	If less than 5 Years indicate other carriers	
Prior Carrier:			
Employer Contribution Amounts (%): (Employee) (Dependent)			
Total # of Full-time ees (including any in the waiting period) _____			
*Please attach a census in an Excel format which includes the following information: Gender, Birthdate/Age, Coverage Election, EE home zip code, Status (Cobra, Retiree, etc..) & Product selection if offering dual option. This template may be used as needed:			
			
M:\Sml_grp_sales\ 51-99 Pending Submis			
Total # Enrolling	# Waiving	# Cobra	# in Waiting period
Is group waiving the waiting period at initial enrollment?			
Is the Domestic Partner rider needed?			

Current Benefits: (Or attach a copy of their current summary of benefits)			
Medical	In	Out of Network	
OV Copay			
ER Copay			
Deductible (Single/Family)			
Coinsurance			
OOP Max (Single/Family)			
Pharmacy			
Current Rates: EE:	ES	EC	F
Renewal Rates: EE:	ES	EC	F
* Please attach a copy of the group's most recent billing statement			
Dental Benefits/Rates:			
Life Benefits/Rates:			
STD/LTD Benefits/Rates:			

Self Funding Information (Required only for groups that are currently Self Funded (ASO))			
Cobra Rates: EE	ES	EC	F
* Please note before final rates can be issued fully completed individual medical apps will be required .			

Broker Name:	:	
Phone :	Fax:	E-Mail:
Are you the current agent?		

Employer Application for Small Business



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.
- 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 the first month's premium.
- 6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

United HealthCare Insurance Company
 Unitedhealthcare of North Carolina, Inc. (HMO)
 Unimerica Insurance Company

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

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
 Ind. Contractor Non-Profit Sole Proprietor Other _____

Nature of Business

Industry (SIC) Code

Multi-Location Group
 Yes No

Locations

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

Hours per week to be eligible

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

Have Worker's Comp
 Yes No

Worker's Comp Carrier Name

Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation:
 See Attached List None

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

Has the Group been insured by UnitedHealthcare in the last 12 months: Yes No If yes, date coverage terminated: / /

Name of Current Medical Carrier
 None

Begin Date ___/___/___
 End Date ___/___/___

Name of Current Dental Carrier
 None

Begin Date ___/___/___
 End Date ___/___/___

Do you currently offer or intend to offer a Health Reimbursement Account plan and/or voluntary or involuntary supplemental insurance (e.g., critical illness, hospital income, deductible reimbursement, etc.) policy along side 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: Definity Standard HRA Definity Select HRA Other Administrator HRA
 Supplemental Insurance Yes No

If you answered "Yes" for HRA, you must choose from the list of Definity HRA-eligible benefit plans as shown to you by your broker or agent. Other plans are not eligible for pairing with a Health Reimbursement Account.

Please check one for medical coverage: (Insurance) UHCIC (HMO) UHC of NC.

Life, dental, vision and other ancillary coverage is provided by United HealthCare Insurance Company (UHCIC) or Unimerica Insurance Company.

Coverage provided by "UnitedHealthCare and Affiliates":

Medical/Dental coverage provided by United HealthCare Insurance Company

Medical coverage provided by Unitedhealthcare of North Carolina, Inc.(HMO)

Life insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

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

YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF 1-50 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.

Participation		# Applying for:	# Waiving for:	Contribution	Employer %	Employee%	Employer % for Dep
# Full Time Employees		Medical	Medical	Medical			
# Part Time Employees		Life	Life	Life			
# Ineligible Employees		Dental	Dental	Dental			
Total # Employees		Vision	Vision	Vision			
		Other	Other	Other			

Optional Benefits: Option selected applies to all plans.

Yes No Chemical Dependency Treatment

Yes No (Religious employer Groups Only) Do you wish to remove contraceptive drugs or devices from the prescription drug coverage subject to (NCGS) 58-3-178(e)?

Questions Regarding Group Size

- COBRA 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.
- St. Continuation
- Medicare 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 their 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.
- Plan Primary
- Yes 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.
- No

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. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. 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. 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

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:	Payee Code	CRID Code	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City		State	Zip Code
Broker Phone #	Broker Email Address		Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.

Broker Signature**Date**

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

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

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

Admin Kit

Send Admin Kit To:	Address
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Group Name: _____

United HealthCare Insurance Company
UnitedHealthcare of North Carolina, Inc. (HMO)

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). **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%; vertical-align: top;"> <input type="checkbox"/> Cancer <input type="checkbox"/> Tumor <input type="checkbox"/> Heart/Circulatory <input type="checkbox"/> Stroke <input type="checkbox"/> Reproductive Disorder <input type="checkbox"/> Intestinal Disorder <input type="checkbox"/> Endocrine Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Brain/Nervous/Seizures <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Immune Disorder </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) <input type="checkbox"/> Chronic Lung Disorder <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Liver Disorders (Hepatitis) <input type="checkbox"/> Back Disorder <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Connective Tissue Disorder <input type="checkbox"/> Lupus <input type="checkbox"/> Other Conditions _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Transplants <input type="checkbox"/> Hemophilia/Blood Disorders <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Immuno deficiency <input type="checkbox"/> Autism </td> </tr> </table>	<input type="checkbox"/> Cancer <input type="checkbox"/> Tumor <input type="checkbox"/> Heart/Circulatory <input type="checkbox"/> Stroke <input type="checkbox"/> Reproductive Disorder <input type="checkbox"/> Intestinal Disorder <input type="checkbox"/> Endocrine Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Brain/Nervous/Seizures <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) <input type="checkbox"/> Chronic Lung Disorder <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Liver Disorders (Hepatitis) <input type="checkbox"/> Back Disorder <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Connective Tissue Disorder <input type="checkbox"/> Lupus <input type="checkbox"/> Other Conditions _____	<input type="checkbox"/> Growth Hormones <input type="checkbox"/> Transplants <input type="checkbox"/> Hemophilia/Blood Disorders <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Immuno deficiency <input type="checkbox"/> Autism
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<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.

Signature	Title	Date	
Group Signature			

NC Medical Benefit Options Checklist (1-99)

	Name: (please print)	Phone #:	Fax #:	Email Address:
Group				
Broker				
Broker Assistant				

- ☆ **NEW! Online Billing:** Effective for 4/1/08 new business, groups with up to 99 lives will be set up for online eligibility & billing. Our online billing & payment capabilities give your clients a comprehensive level of account information. To opt out and request paper billing rather than online, please let us know.
- ☆ **Online Welcome Kit:** Please note that we will distribute all welcome materials electronically as a default. Welcome kits will be available online through myuhc.com and Employer eServices. This will include Certificates of Coverage and will replace all previously printed welcome materials. To opt out and request printed rather than online materials, please let us know.

Waiting Period Options (Choose 1 option in each section)		Renewal Date:
<input type="checkbox"/> Date of Event, or <input type="checkbox"/> First of the month	Days: <input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 60** <input type="checkbox"/> 90** (**available with date of event only), or Months: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 st of the Month, or <input type="checkbox"/> 15 th of the Month
Does group want to waive Waiting Period for employees hired prior to effective date? <input type="checkbox"/> Yes or <input type="checkbox"/> No		
The deductible/out of pocket should run: <input type="checkbox"/> Policy Year (Effective Date – Renewal Date) or <input type="checkbox"/> Calendar Year (1/1 – 12/31)		
How long has the group been in business? _____		

Medical Plans (Choose only 1 option) NOT BINDING			
Split Copay	No Copay	Value	Pharmacy
<input type="checkbox"/> S3-C (Balanced 25/1000/70%)	<input type="checkbox"/> S1-Q (Consumer 1000/70%)	<input type="checkbox"/> S2-D (Consumer 1500/70%)	<input type="checkbox"/> H9
<input type="checkbox"/> S1-E (Balanced 25/1000/80%)	<input type="checkbox"/> 70-Q (Consumer 1000/80%)	<input type="checkbox"/> S2-H (Consumer 1500/80%)	<input type="checkbox"/> 4F
<input type="checkbox"/> S3-E (Balanced 25/1500/70%)	<input type="checkbox"/> S1-R (Consumer 1500/70%)	<input type="checkbox"/> S2-O (Balanced 25/1500/70%)	<input type="checkbox"/> Y6
<input type="checkbox"/> S1-F (Balanced 25/1500/80%)	<input type="checkbox"/> S1-W (Consumer 1500/80%)	<input type="checkbox"/> S2-S (Balanced 25/1500/80%)	<input type="checkbox"/> 0H
<input type="checkbox"/> S1-A (Balanced 25/2000/70%)	<input type="checkbox"/> S1-S (Consumer 2000/70%)	<input type="checkbox"/> S2-W (Balanced 100 25/2500/100%)	<input type="checkbox"/> 2V
<input type="checkbox"/> S1-G (Balanced 25/2000/80%)	<input type="checkbox"/> S1-X (Consumer 2000/80%)	<input type="checkbox"/> S2-P (Balanced 25/2500/70%)	<input type="checkbox"/> 5U
<input type="checkbox"/> S1-M (Balanced 100 25/2500/100%)	<input type="checkbox"/> S2-A (Consumer 2500/100%)	<input type="checkbox"/> S2-T (Balanced 25/2500/80%)	<input type="checkbox"/> 0I
<input type="checkbox"/> S1-B (Balanced 25/2500/70%)	<input type="checkbox"/> S1-T (Consumer 2500/70%)	<input type="checkbox"/> S2-K (Consumer 2500/100%)	<input type="checkbox"/> G4
<input type="checkbox"/> S1-I (Balanced 25/2500/80%)	<input type="checkbox"/> S1-Y (Consumer 2500/80%)	<input type="checkbox"/> S2-E (Consumer 2500/70%)	<input type="checkbox"/> 5S
<input type="checkbox"/> S1-N (Balanced 100 25/3500/100%)	<input type="checkbox"/> S2-B (Consumer 3500/100%)	<input type="checkbox"/> S2-I (Consumer 2500/80%)	<input type="checkbox"/> Y7
<input type="checkbox"/> S1-C (Balanced 25/3500/70%)	<input type="checkbox"/> S1-U (Consumer 3500/70%)	<input type="checkbox"/> S2-X (Balanced 100 25/3500/100%)	<input type="checkbox"/> AQ
<input type="checkbox"/> S1-O (Balanced 100 25/5000/100%)	<input type="checkbox"/> S2-C (Consumer 5000/100%)	<input type="checkbox"/> S2-Q (Balanced 25/3500/70%)	<input type="checkbox"/> 6M
<input type="checkbox"/> S1-D (Balanced 25/5000/70%)	<input type="checkbox"/> S1-V (Consumer 5000/70%)	<input type="checkbox"/> S2-L (Consumer 3500/100%)	<input type="checkbox"/> 5V
<input type="checkbox"/> S1-K (Balanced 25/5000/80%)	<input type="checkbox"/> S1-Z (Consumer 5000/80%)	<input type="checkbox"/> S2-F (Consumer 3500/70%)	<input type="checkbox"/> AT
<input type="checkbox"/> S1-L (Balanced 100 25/10000/100%)	Definity HSA	<input type="checkbox"/> S2-Y (Balanced 100 25/5000/100%)	<input type="checkbox"/> S8
<input type="checkbox"/> S3-D (Balanced 25/10000/70%)	<input type="checkbox"/> 7A-T* (Definity HSA 2000/100%)	<input type="checkbox"/> S2-R (Balanced 25/5000/70%)	<input type="checkbox"/> 5T
Traditional	<input type="checkbox"/> 1A-Y* (Definity HSA 2000/80%)	<input type="checkbox"/> S2-U (Balanced 25/5000/80%)	<input type="checkbox"/> AS
<input type="checkbox"/> S1-J (Trad w/Ded 25/500/80%)	<input type="checkbox"/> S4-C* (Definity HSA 2850/100%)	<input type="checkbox"/> S2-M (Consumer 5000/100%)	<input type="checkbox"/> AR
<input type="checkbox"/> S3-A (Trad w/Ded 500/80%)	<input type="checkbox"/> S4-A* (Definity HSA 2850/80%)	<input type="checkbox"/> S2-G (Consumer 5000/70%)	<input type="checkbox"/> CQ
State Mandated	<input type="checkbox"/> S4-D* (Definity HSA 3500/100%)	<input type="checkbox"/> S2-J (Consumer 5000/80%)	<input type="checkbox"/> 6N
<input type="checkbox"/> 32M* Rx: Not available	<input type="checkbox"/> S4-B* (Definity HSA 3500/80%)	<input type="checkbox"/> S2-V (Balanced 100 25/10000/100%)	<input type="checkbox"/> 5W
<input type="checkbox"/> 32N* Rx: 50% coverage		<input type="checkbox"/> S2-N (Balanced 25/10000/70%)	<input type="checkbox"/> AU

HRA	Dual Option						
An HRA can be placed with any of our medical plans except (notated above with an *): <ol style="list-style-type: none"> Plans with less than \$100 individual in-network deductible HSA High Deductible Health Plans 	For valid package combinations, please see the Dual Option grids on www.unitedeservices.com under Products > Product Grids.						
Is this an HRA Class-out? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following): Class 1 (define): _____ Class 1: Med Plan Code: _____ Rx Plan Code: _____ w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N Class 2 (define): _____ Class 2: Med Plan Code: _____ Rx Plan Code: _____ w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N	Write in plan choices below: <table border="1"> <tr> <td>Plan 1: w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N</td> <td>Med Plan Code</td> <td>RX Plan Code</td> </tr> <tr> <td>Plan 2: w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N</td> <td>Med Plan Code</td> <td>RX Plan Code</td> </tr> </table>	Plan 1: w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N	Med Plan Code	RX Plan Code	Plan 2: w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N	Med Plan Code	RX Plan Code
Plan 1: w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N	Med Plan Code	RX Plan Code					
Plan 2: w/HRA? <input type="checkbox"/> Y or <input type="checkbox"/> N	Med Plan Code	RX Plan Code					

Preliminary rates will be adjusted to reflect actual enrollment and underwriting risk assignment for final rates. Rates are not final until a group number and installation summary is released.

Group Name: _____

Standard Industry Code (SIC): _____

Nature of Business : _____

Important Notes:

Ancillary benefits are NOT guaranteed for all eligible employees.

Some industries may not be eligible for Life/AD&D/Dental Coverage



LIFE / AD&D OPTIONS AVAILABLE						DENTAL OPTIONS AVAILABLE																																					
☆ Life not available on groups size 2-5 without purchase of medical. ☆ Life amounts > GI will be underwritten and require the 14 Question Employee Application.						Employer Contribution: (Write In) _____ %	Employer Contribution:		Participation Requirement:																																		
Selection:	Employer Contribution:		Participation Requirement:																																								
<input type="checkbox"/>	Non-Contributory (100%)		100%																																								
<input type="checkbox"/>	Contributory (25-99%)		75% minimum (on group size 2-9 all but 1 ee must participate)																																								
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width: 10%;">1-50</th> <th style="width: 10%;">51-99</th> <th colspan="4">Eligibility Definition (choose one):</th> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="4">All employees taking medical <u>excluding</u> waivers</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="4">All employees taking medical <u>including</u> waivers</td> </tr> </table>						1-50	51-99	Eligibility Definition (choose one):				<input type="checkbox"/>	<input type="checkbox"/>	All employees taking medical <u>excluding</u> waivers				<input type="checkbox"/>	<input type="checkbox"/>	All employees taking medical <u>including</u> waivers				How many years has the group had Dental coverage? _____ Ortho coverage? _____																			
1-50	51-99	Eligibility Definition (choose one):																																									
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Note: 1-99= Life/AD&D reduces 35% at age 65 & 50% at age 70.						Voluntary (Indemnity) <input type="checkbox"/> I0675 <input type="checkbox"/> I0676* <input type="checkbox"/> I0677																																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"># Eligible EE's:</th> <th rowspan="2">Guarantee Issue Amount:</th> <th colspan="2">Flat Amount Options:</th> <th colspan="2">Multiple of Salary Options:</th> </tr> <tr> <th colspan="2">Min/Max Amount (in increments of \$5,000 up to):</th> <th colspan="2">(up to max amount listed in previous column, can set lower).</th> </tr> </thead> <tbody> <tr> <td>2-5</td> <td>\$25,000</td> <td colspan="2">\$15,000 - \$50,000</td> <td colspan="2">1X or 2X Salary</td> </tr> <tr> <td>6-19</td> <td>\$50,000</td> <td colspan="2">\$15,000 - \$175,000</td> <td colspan="2">1X or 2X Salary</td> </tr> <tr> <td>20-50</td> <td>\$100,000</td> <td colspan="2">\$15,000 - \$250,000</td> <td colspan="2">1X or 2X Salary</td> </tr> <tr> <td>51-99</td> <td>\$175,000</td> <td colspan="2">\$15,000 - \$350,000</td> <td colspan="2">1X or 2X Salary</td> </tr> </tbody> </table>						# Eligible EE's:	Guarantee Issue Amount:	Flat Amount Options:		Multiple of Salary Options:		Min/Max Amount (in increments of \$5,000 up to):		(up to max amount listed in previous column, can set lower).		2-5	\$25,000	\$15,000 - \$50,000		1X or 2X Salary		6-19	\$50,000	\$15,000 - \$175,000		1X or 2X Salary		20-50	\$100,000	\$15,000 - \$250,000		1X or 2X Salary		51-99	\$175,000	\$15,000 - \$350,000		1X or 2X Salary		Voluntary (PPO) <input type="checkbox"/> P3300* <input type="checkbox"/> P3327 <input type="checkbox"/> P3329 <input type="checkbox"/> P3346 <input type="checkbox"/> P3374* <input type="checkbox"/> P3381 <input type="checkbox"/> P3382* <input type="checkbox"/> P3383* <input type="checkbox"/> P3384 <input type="checkbox"/> P3385 <input type="checkbox"/> P3386 <input type="checkbox"/> P3387* <input type="checkbox"/> P3378 <input type="checkbox"/> P3379* <input type="checkbox"/> P3388* <input type="checkbox"/> P3389 <input type="checkbox"/> P3320 <input type="checkbox"/> P3322			
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Benefit Selection:						ER Sponsored (Indemnity) <input type="checkbox"/> I0002 <input type="checkbox"/> I0003* <input type="checkbox"/> I0007 <input type="checkbox"/> I0008* <input type="checkbox"/> I0009 <input type="checkbox"/> I0012* <input type="checkbox"/> I0014* <input type="checkbox"/> I0026 <input type="checkbox"/> I0028* <input type="checkbox"/> I1052 <input type="checkbox"/> I1053 <input type="checkbox"/> I1310* <input type="checkbox"/> I1311* <input type="checkbox"/> I1312 <input type="checkbox"/> I1313 <input type="checkbox"/> I1314 <input type="checkbox"/> I1315*																																					
Flat Amount						Dual Option Dental Selections																																					
A. <input type="checkbox"/> Flat Amt / EE: \$ _____			C. <input type="checkbox"/> _____ X Salary / EE			Plan 1: _____		Plan 2: _____																																			
B. <input type="checkbox"/> Class Base Flat Amount: (cannot be more than 2.5X difference b/n classes)			D. <input type="checkbox"/> Class Base Multiple of Salary: (cannot be more than 2.5X difference b/n classes)			* Indicates an Ortho plan that requires a minimum of 10 eligible with 8 enrolling EEs BOLD Indicates a plan that has a 12 month waiting period on Major & Ortho (if applicable). To waive the waiting period a prior dental billing statement reflecting 12 mo. coverage and their plan summary showing major & ortho. coverage will need to be provided. <i>ITALICS</i> indicate a Consumer MaxMultiplier plan.																																					
Class:	Description:	Amount:	Class:	Description:	Amount:	VISION OPTIONS AVAILABLE																																					
I		\$ _____	I		_____ X Salary	Participation:	100% ER Paid:		Voluntary:		Buy-Up:																																
II		\$ _____	II		_____ X Salary		w/Medical- 75%	Min. 2 eligible EEs w/1 taking		w/Medical- 75%																																	
III		\$ _____	III		_____ X Salary		Stand Alone- 100%	80-100% EE & Dependent		0-49%		80-100% EE; 0% Dependent																															
DEPENDENT LIFE OPTIONS AVAILABLE						ER Contribution:		Plan:		100% ER Paid:		Voluntary:		Buy-Up:																													
Employer Contribution: (Write In)		Employer Contribution:		Participation Requirement:		1		2		3		4																															
_____ %		Non-Contributory (100%)		100%		_____ %		_____ %		_____ %		_____ %																															
_____ %		Contributory (0-99%)		75% minimum		_____ %		_____ %		_____ %		_____ %																															
Selection:		Plan:		Spouse / Child:		<input type="checkbox"/> V0001		<input type="checkbox"/> V0002		<input type="checkbox"/> V0003		<input type="checkbox"/> V0004		<input type="checkbox"/> V0005																													
<input type="checkbox"/>		Plan A		\$7,500 / \$3,750		<input type="checkbox"/> V0006		<input type="checkbox"/> V0007		<input type="checkbox"/> V0008		<input type="checkbox"/> V0009		<input type="checkbox"/> V0010																													
<input type="checkbox"/>		Plan B		\$4,000 / \$2,000		<input type="checkbox"/> V0011		<input type="checkbox"/> V0012		<input type="checkbox"/> V0013		<input type="checkbox"/> V0014		<input type="checkbox"/> V0015																													
<input type="checkbox"/>		Plan C		\$2,000 / \$1,000		<input type="checkbox"/> V0016		<input type="checkbox"/> V0017		<input type="checkbox"/> V0018		<input type="checkbox"/> V0019		<input type="checkbox"/> V0020																													
<input type="checkbox"/>		Plan D		\$10,000 / \$5,000		<input type="checkbox"/> V0021		<input type="checkbox"/> V0022		<input type="checkbox"/> V0023		<input type="checkbox"/> V0024		<input type="checkbox"/> V0025																													
<input type="checkbox"/>		Plan E		\$5,000 / \$2,500		<input type="checkbox"/> V0026		<input type="checkbox"/> V0027		<input type="checkbox"/> V0028		<input type="checkbox"/> V0029		<input type="checkbox"/> V0030																													

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 _____

Employee Enrollment Form

United HealthCare Insurance Company
Unitedhealthcare of North Carolina, Inc. (HMO)
Unimerica Insurance Company

To speed the enrollment process, please be thorough and fill out all sections that apply.

Group Name/Number

To Be Completed by Employer Requested Effective Date of Coverage/Date of Change / /

Date of Hire / /	Reason for Application <input type="checkbox"/> New Group Plan <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Other _____	Employee Type (Check all that apply) <input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Active <input type="checkbox"/> COBRA/State Continuation <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired	Start dt / / End dt / /
Position/Title			
Hours Worked per week			
Salary \$ _____ Required only if Life Plan based on salary			

A. Employee Information

Last Name	First Name	MI	Social Security Number	Home Phone	Work Phone
Address	Apt #	City	State	Zip Code	Email Address
Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language preference, if not English
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Physician* (First & Last Name)/ ID #		Primary Care Dentist (First & Last Name)/ ID #		

B. Family Information

Last Name		First Name	MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (Name/ID#)	Tobacco Used
Social Security Number											
_ _ - _ - _ _											
		M		Spouse					<input type="checkbox"/>		<input type="checkbox"/> Yes
		F							<input type="checkbox"/>		<input type="checkbox"/> No
		M		Dependent					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		F							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		M		Dependent					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		F							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents, for UnitedHealthcare Select, Select Plus, and other products requiring a Primary Physician designation only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

Please check one (with a box) for medical coverage: (Insurance) UHCIC (HMO) UHC of NC.
Life, dental, vision and other ancillary coverage is provided by United HealthCare Insurance Company (UHCIC) or Unimerica Insurance Company.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection. Dual Option Plan Selected

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Medical	Dental
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"/>						

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

Coverage provided by "UnitedHealthCare and Affiliates":
Medical/Dental coverage provided by United HealthCare Insurance Company
Medical coverage provided by Unitedhealthcare of North Carolina, Inc.(HMO)
Life insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company.

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.

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*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, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (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

