UnitedHealthcare Level Funded – Plan Sponsor Application

Have you:

- Signed all forms necessary for health plan application?
- Answered all applicable questions?
- Selected a method of payment?
- Enclosed a check for the initial payment?
- Enclosed a voided check if you selected Electronic Funds Transfer?

Please send correspondence to:
P.O. Box 31394
Salt Lake City, UT 84131
1-877-797-8816

Plan Sponsor Data

Plan Sponsor Tax ID No.			
Full Legal Business Name			
Street Address	City	State	ZIP Code
Mailing Address (if different)	City	State	ZIP Code
Phone No.	Fax No.	County	
Nature of Business	SIC	Date Business Started	
Administrative Contact Person	Executive Contact Person		
Contact Person email			
Third-Party Administrator **United HealthCare Services Inc.**	Legal Name of the Plan		

☐ Yes ☐ No Is your company (you) subject to COBRA? (Your company is subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full- or part-time plan participants on at least 50 percent of the typical business days during the previous calendar year. You must include plan participants residing outside of the United States. Church plans and federal, state and local government plans are excluded from COBRA.) Give the names of persons currently under COBRA, state continuation plan or within their election period:

Plan Participant/Dependent Name	Termination Date of Employment or Qualifying Event	Plan Participant/Dependent Name	Termination Date of Employment or Qualifying Event

☐ Yes ☐ No Has your company ever had a group insurance application denied by an insurer? If yes, give name of insurer, date and reason:

☐ Yes ☐ No Is current group medical coverage being replaced?

List the name, address and phone number of your company's present medical carrier or Third-Party Administrator (TPA)

Carrier Name			
Carrier Address	City	State	ZIP Code
Carrier Phone No.	Effective Date	Termination Date	

☐ Yes ☐ No Has your medical plan been previously underwritten or administered by UnitedHealthcare Insurance Company or any of its affiliates in the last 3 years?

Indicate the Plan Sponsor contribution amounts
(minimum contribution 50% of plan participant only premium):
What percentage of the costs will you pay for plan participants? _____%

For dependents (spouse and children)? _____%

Indicate the Plan Sponsor Default Plan:
Which default plan did you choose for your business? (Include the letter and number of the plan code) _____

Additional Plans Elected: (If applicable) _____

What class of plan participants do you want to exclude from this plan? (Check all that apply.)
☐ None ☐ Union ☐ Non-Union ☐ Hourly ☐ Salary ☐ Non-management ☐ Management

Medical Benefit Plan Option (where available)
☐ Calendar Year ☐ Plan Year

continued

Plan Sponsor/Plan Participant

How many plan participants does your company currently have on the payroll? _____

Plan participants working a minimum of 30 hours per week (not part time, temporary or substitute) are Eligible Plan Participants:

Number of Eligible Plan Participants _____

Number of Eligible Plan Participants Waiving Coverage _____

Number of Enrolling Plan Participants _____

Prior calendar year average total number of plan participants _____

Under Health Care Reform law, the number of plan participants means the average number of plan participants employed by the company during the preceding calendar year. An plan participant is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly plan participant totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of plan participants at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior-year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Waiting Period Waived for Initial Enrollees ☐ Yes ☐ No

Plan Participant Effective Date

- ☐ Immediate after date of hire
- ☐ Immediate after 30 days
- ☐ Immediate after 60 days
- ☐ Immediate after 90 days
- ☐ First of month after date of hire
- ☐ First of month after 30 days
- ☐ First of month after 60 days

Plan Participant Termination Date: ☐ End of month

Leave of Absence (LOA) Policy

If the plan participant is on an plan sponsor approved leave of absence and the plan sponsor continues to pay required payments, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e., temporarily laid-off) and (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by federal rules such as COBRA.

If the plan participant's medical coverage terminates under this LOA policy, the plan participant may exercise the rights under any applicable continuation of coverage under federal law (COBRA) as described in the Summary Plan Description.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

☐ Yes, we continue medical coverage during an approved leave of absence for plan participants.
☐ No, we do not offer medical coverage during a leave of absence.

☐ Yes ☐ No Does your current health insurer extend coverage for disabilities after termination date? (If yes, provide copy of policy and/or plan participant certificate.)

Consumer Driven Health Plan Options

Health Savings Account (if selected): Which bank will be used: ☐ OptumBank ☐ Other

Eligibility for Medical Coverage

☐ Medicare Primary
☐ Plan Primary

Under federal law, if your group had 20 or more plan participants 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.

☐ Yes ☐ No Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO) or Administrative Services Organization (ASO)?

☐ 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) or 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 who 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.

☐ Yes ☐ No Does your group sponsor a plan that covers employees of more than one plan sponsor?

If you answered Yes, then indicate which of the following most closely describes your plan:

- ☐ Professional Employer Organization (PEO)
- ☐ Multiple Employer Welfare Arrangement (MEWA)
- ☐ Taft Hartley Union
- ☐ Governmental
- ☐ Church
- ☐ Employer Association

☐ Yes ☐ No Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Effective Date

Enrollment forms may be submitted with a requested effective date. The effective date will be determined by the Third-Party Administrator in accordance with the provisions of the Summary Plan Description. Do not cancel your current coverage. Coverage is not in effect until you receive written confirmation from the Third-Party Administrator.

Requested Effective Date:_____.

continued

Payment: Cash with Application/Applicable Fees

The group's first month payment plus all applicable fees must be submitted by check with this form or by EFT (Electronic Funds Transfer). All future payments must be paid with a plan sponsor's check or automatically withdrawn through the plan sponsors bank account. Checks must be made out to United HealthCare Services, Inc.

A $25 fee will apply for each future payment made by Direct Bill (does not apply to the first month's payment submitted with the application). The billing fee covers the cost of monthly processing of each account. Nonpayment of this fee will result in termination of the Administrative Services Agreement and Excess Loss Insurance coverage. Payments made by Electronic Funds Transfer do not have a billing fee.

Total Payment Deposit: $_____ A service fee will be applied to non-sufficient funds.

Plan Sponsor Agreement

The agent has explained the details of the coverage and I, the undersigned, acknowledge reading the entire application. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Applicant and United HealthCare Services, Inc. only when the Application receives written approval from United HealthCare Services, Inc.

All enrollees requesting or changing coverage must submit complete medical history. Approval of such changes is subject to United HealthCare Services, Inc. underwriting guidelines. All late enrollees will be declined or excluded for a period of time. Late enrollees are those whose enrollment form is received more than 31 days following their initial eligibility date.

Important Information
UnitedHealthcare reserves the right to review the applicant's payroll/wage and tax records at any time to confirm eligibility. UnitedHealthcare may request the applicant's most recent wage and tax payroll records. The applicant agrees to furnish UnitedHealthcare with all information and documentation which may be reasonably required with regard to eligibility for coverage.

I understand that the information provided on this application and on the Plan Participant Enrollment Application Form is used to make decisions regarding eligibility and pricing. I also understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake) by the Plan Sponsor, agent of the Plan Sponsor, Plan Participant covered under the Plan, could materially affect the underwriting, premium, rating or terms and conditions of the Plan Sponsor's Excess Loss Coverage. In addition, such misrepresentation, concealment, omission of fact or a mistake of fact (whether or not a mutual mistake) could result in increased premium rates, attachment points and/or otherwise change the terms and conditions of the Plan Sponsor's Excess Loss Insurance Policy retroactive to the effective date or as of any premium due date thereafter or termination of that Policy as of the next premium due date. I also understand that the Excess Loss Insurance Policy may be declared null and void in its inception if the Plan Sponsor, any agent of the Plan Sponsor, or Plan Participant covered under the Plan has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of the Excess Loss Insurance Policy.

I further certify that Plan Sponsor is a plan sponsor eligible to sponsor a group health plan under federal law known as ERISA. I also certify that the individuals covered under the Plan Sponsor's group health plan are common law plan participants. United HealthCare Services, Inc. or its affiliates reserves the right to terminate the parties' agreement in the event that information shows that the Plan Sponsor is not eligible to sponsor a group health plan.

Coverage is not in effect until the undersigned receives written approval from United HealthCare Services, Inc. Final approval or disapproval is not taken on the Application until all required information in the Application and all required information for enrolling plan participants and their dependents is submitted and reviewed. No person other than an officer of United HealthCare Services, Inc. has the authority to bind or alter coverage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to the Plan Sponsor if coverage is declined.

United HealthCare Services, Inc. reserves the right to contact any plan participant at the place of business to complete the enrollment process. Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be guilty of insurance fraud, which is a crime, and may be subject to fines and confinement in prison.

Important Notice for Government Contractors: The UnitedHealthcare Level Funded product is not available to any government contractor which is prohibited by contract, regulation or otherwise from receiving a refund or credit of any surplus or money (including the refund or credit of surplus under the Level Funded product) that was allocated under their government contract to pay for plan participant benefits. If you have any questions about whether you are subject to such a prohibition, please consult with your legal counsel, as United HealthCare Services, Inc. is not able to provide you with legal advice on such matters. By completing and signing this application, you are representing to United HealthCare Services, Inc. that you are not prohibited by government contract, regulation or otherwise from receiving a refund or credit of any surplus or money under the Level Funded product.

Unless all pages are attached and completed, this will not be considered as a complete Application.

Dated at (City and State) _____ Dated on (Month, Day and Year) _____

Legal Business Name _____

Signature X_____(Must be signed by a person authorized to purchase coverage for the Plan Sponsor.)

Print Name and Title _____

General Agent Information

General Agent _____ Telephone No. _____ NPN# _____

Street Address _____ City _____ State ____ ZIP Code_____

Producer Information

I hereby certify that all information contained in this form has been explained to the Plan Sponsor and that the answers are correct to the best of my knowledge. I am not aware of anything unfavorable about the Plan Sponsor or any person proposed for coverage except as noted herein. I have complied with the underwriting rules and regulations of the Third-Party Administrator and have explained to the Plan Sponsor the coverages, limitations and exclusions, and other details of the coverage applied for.

I have notified the Plan Sponsor not to terminate present coverage until notified in writing by United HealthCare Services, Inc. of acceptance of this Application.

Producer Name _____

Address _____

Telephone No. _____ Fax No. _____

Social Security/Identification No._____

Producer Signature X_____ Date _____

continued

Case Submission

Please submit the following forms for application of coverage:

- ☐ Plan Sponsor Application form
- ☐ Plan Participant Enrollment forms
- ☐ Payment Authorization form
- ☐ First month's payment
- ☐ A copy of the quoted rates
- ☐ Excess Loss Insurance Application
- ☐ Most recent copy of Wage and Tax Report

OFFICE USE ONLY

Group Effective Date _____ Approved By _____ Date _____

Comments _____

UnitedHealthcare Level Funded Payment Authorization Form

Send initial check to:
United HealthCare Services, Inc.
P.O. Box 959782
St. Louis, MO 63195-9782
(If overnighting the check, please use UHS Billing,
Attn: Lockbox 959782, 1005 Convention Plaza, St. Louis, MO 63101)

A. APPLICANT INFORMATION

Plan Sponsor Name _____

B. INITIAL METHOD OF PAYMENT

- ☐ Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)
- ☐ Check Enclosed

C. ONGOING METHOD OF PAYMENT

- ☐ Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)
- ☐ Direct Bill – Monthly (Fees may apply)

D. STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Deposit, I agree to and/or understand all of the following on behalf of my business:

It may take up to 1 month to establish this process.

I authorize United HealthCare Services, Inc. to debit my business checking or savings account for the monthly payment for Administrative Services, Excess Loss Insurance, and claim funding. I will ensure sufficient funds are in my business checking or savings account to cover my monthly payment. If the necessary funds are not on deposit in the account at the beginning of the month, my Administrative Services Agreement with United HealthCare Services, Inc. and Excess Loss Insurance policy with All Savers Insurance Company may be subject to termination under the terms stated in the contracts. Also, I understand my business may be subject to additional service fees incurred by United HealthCare Services, Inc. subsequent to the termination date as a result of insufficient funds.

I will promptly notify United HealthCare Services, Inc. of any change to my business checking or savings account. If a change occurs, it is my responsibility to provide United HealthCare Services, Inc. with the current information.

E. ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Type of Account: ☐ Checking ☐ Savings

Account Holder's Name _____ Financial Institution _____
(As it appears on financial institution records.)

Routing/Transit Number (9 digits required) _____ Account Number _____

I (we) hereby authorize United HealthCare Services, Inc. to initiate debit entries to the account and the financial institution named above. In submitting this payment authorization with the application, I understand that the initial payment may be adjusted based on the applicant's medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. United HealthCare Services, Inc. will not be held responsible for a contract lapse or termination due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid. United HealthCare Services, Inc. is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until United HealthCare Services, Inc. has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days' advance notice to terminate or change this authorization. If the automatic bank draft or direct payment by check transaction is returned for any reason, a $25 nonrefundable service fee will be applied.

Authorized or Account Holder Signature X_____ Date _____

Plan Sponsor's Email Address _____

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA.

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United Healthcare