

Common Ownership Certification



Please complete, sign and submit the Common Ownership Certification.

Renewing Groups- complete and return even if you do not have multiple companies.

Please list all companies that are eligible to be included as part of a consolidated federal tax return (even if they don't file a consolidated federal tax return) or who are part of a controlled group as defined under the Internal Revenue Code. *When listing the number of Eligible, count the number of Eligible employees for each business, even if they're not offered this insurance.

Customer Name: _____

Group Number (if renewal): _____

Primary Business Location: _____

Please check one of the following:

☐ I certify that my business applying for coverage with UnitedHealthcare is not part of a controlled group (commonly owned or affiliates) as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. (Single business that has no common ownership/affiliates)

Or

☐ I certify that my business(es) applying for coverage with UnitedHealthcare (1) is eligible to file a consolidated federal tax return or (2) meets the IRS test for being a controlled group or affiliated service group as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. I further certify there are no other affiliated entities, other than the ones listed below, who are part of the controlled group affiliated service group that includes my business.

<u>Business Name:</u>	<u>Federal Tax ID #:</u>	<u># of Eligible*:</u>	<u>On This Policy:</u>
1. _____	_____	_____	Yes / No
2. _____	_____	_____	Yes / No
3. _____	_____	_____	Yes / No
4. _____	_____	_____	Yes / No
5. _____	_____	_____	Yes / No
6. _____	_____	_____	Yes / No

The undersigned certifies that the foregoing information is true, correct and complete, and fully understands that any false statements or failure to provide all available information may constitute the basis for rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Name (please print) & Title:

Signature:

Date: