CALIFORNIA
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/covered and current status.
4. Submit most recent wage and tax information.
5. Include a deposit check for any required premiums.
6. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

UnitedHealthcare Insurance Company
UnitedHealthcare of California
UnitedHealthcare Benefits Plan of California

General Information

				Effective Date
Group's Legal Name				Tax ID
DBA, if applicable				
Group name to appear on ID card (maximum 30 characters and spaces)				
Address				Start Date of Business
City	State	Zip Code	Telephone	Fax
Billing Contact / Title		Telephone	Email Address	
Billing Address (If different)				
Executive Contact / Title		Telephone	Email Address	
Administrative / Service Contact / Title		Telephone	Email Address	

Organization Type: ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Non-Profit ☐ Sole Proprietor ☐ Other _____

Did you have any employees other than yourself and your spouse or registered domestic partner during the preceding calendar year? ☐ Yes ☐ No

Did you have at least one non-spouse common-law employee during the prior calendar year? ☐ Yes ☐ No

Nature of Business

Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No	# of Locations	Address(es) (Use additional sheet of paper if necessary)

*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

#of hours per week to be eligible	Classes Excluded (if applicable):	Waiting Period for New Hires (Not to exceed 90 calendar days)	Waiting Period for Rehire	Waiting Period Waived for Initial Enrollees
	☐ None ☐ Union ☐ Hourly (# of hours_____) ☐ Non-Management	☐ 1st of the month following Date of Hire ☐ 1st of the month following _____ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ _____ [months] [days] of employment following Date of Hire	☐ 1st month following _____ [months] _____ [days]	☐ Yes ☐ No

Subject to ERISA Regulation ☐ Yes ☐ No

(Most private sector plans are ERISA plans)

If No, please indicate appropriate category
☐ Church (Additional information needed)
☐ Indian Tribe – Commercial Business
☐ Foreign Government/Foreign Embassy
☐ Federal Government
☐ Non-Federal Government (State, Local or Tribal)
☐ Non-ERISA Other

Have Workers' Comp ☐ Yes ☐ No	Workers' Comp Carrier Name or Reason if no coverage	Names of Owners/Partners not covered by Workers' Comp

Names of Persons currently on COBRA/Continuation:

Name		COBRA Qualifying Event	COBRA Date of Qualifying Event
	☐ COBRA ☐ Cal-COBRA ☐ COBRA-AB1401 ☐ Extended/Disabled COBRA		
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Coverage provided by "UnitedHealthcare and Affiliates":

Check appropriate box(es) for coverage(s) selected:

Medical ☐ UnitedHealthcare Insurance Company or ☐ UnitedHealthcare Benefits Plan of California (Insurance Products: Navigate, Select Plus, Core, Doctors Plan, Non-Differential PPO)

Medical ☐ UnitedHealthcare of California (HMO)

Dental ☐ UnitedHealthcare Benefits Plan of California or ☐ UnitedHealthcare Insurance Company or ☐ Dental Benefit Providers of California, Inc.

Vision ☐ UnitedHealthcare Benefits Plan of California or ☐ UnitedHealthcare Insurance Company

Administrative services provided by United Healthcare Services, Inc. Optum Rx Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

General Information (continued)

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

		Name of Carrier	Coverage Begin Date	Coverage End date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Vision Carrier	☐ None			

UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

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

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or Conversion of Medical Benefits provision described in the Certificate of Coverage.

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 full-time employees (as defined below).

___ No, we do not offer medical coverage during a leave of absence.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Full-Time (30 hours per week over the course of a month) Eligible Employees Enrolling in CA		Medical		Medical		Medical		
# Part-Time (20-29 Hours) Eligible Employees Enrolling in CA		Dental		Dental		Dental		
# Full-Time (30+ Hours) Eligible Employees Enrolling Outside of CA		Vision		Vision		Vision		
# Part-Time (20-29 Hours) Eligible Employees enrolling Outside of CA		Other		Other		Other		
# Employees in Waiting Period (Not exceed 90 calendar days)								
Total # Employees Waiving								
# Ineligible Employees (other than noted above)								
Total # Employees								

Questions Regarding Group Size

☐ COBRA ☐ State continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year. If your group had fewer than 20 employees during a calendar year, you must provide State Continuation effective January 1 of the next calendar year.
☐ Medicare Primary ☐ 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.
Enter the Prior Calendar Year Average Total Number of Employees _____	Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee 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 employee 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 employees 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).

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Questions Regarding Group Size (continued)	
Enter the Prior Calendar Year Total Number of Eligible Employees _____	For purposes of determining your number of eligible employees, Eligible employees are those who are eligible to enroll in any medical plan you offer, even if they aren't eligible to enroll in a UnitedHealthcare plan. Here you may add COBRA and retirees. Calculate your number of eligible employees from the preceding calendar year: (1) Count the total number of eligible employees at the end of each month (2) Add all the monthly eligible totals from line (1) and divide by 12. Use whole numbers only (no decimals, fractions or ranges and round down).
Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees _____	For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.
☐ 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 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.
☐ Yes ☐ No	Does your group sponsor a plan that covers employees of more than one employer? If you answered Yes, then indicate which of the following most closely describes your plan: ☐ Professional Employer Organization (PEO) ☐ Governmental ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Church ☐ Taft Hartley Union ☐ 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.
☐ Yes ☐ No	I affirmatively agree to receive on behalf of and promptly send to each subscriber/insured in the group any Notice of Cancellation, Rescission, or Nonrenewal.
☐ Yes ☐ No	I affirmatively agree to receive on behalf of and promptly send to each subscriber/insured in the group any Notice of End of Coverage.

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Important Information

I understand that the Evidence of Coverage, Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application, herein referred to as "Disclosure Materials," will be transmitted electronically to the Group/Company.

I acknowledge and affirmatively agree, on behalf of the Group/Company, to provide the applicable Disclosure Materials provided by UnitedHealthcare and Affiliates that contain information regarding benefits, services, exclusions, limitations and terms of the enrollee's health care coverage in electronic form and/or hard copy to enrolled members in accordance with California and federal laws, so as to afford the enrollee full and fair disclosure.

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. If UnitedHealthcare can demonstrate you committed an act or practice that constituted fraud or an intentional misrepresentation of a material fact, it may result in rescission of the group/company policy/agreement, termination of coverage, or increase in premiums retroactive to the original effective date of the agreement/policy. UnitedHealthcare will issue a written notice via regular certified mail at least 30 days prior to the effective date of the rescission explaining the basis for the decision of rescission and your appeal rights. After 24 months following the issuance of the agreement/policy, UnitedHealthcare will not rescind the agreement/policy for any reason, and will not cancel the agreement/policy, limit any of the provisions of the agreement/policy, or increase premiums on the agreement/policy due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not. Group/Company will receive any notices for failure to pay and/or termination in writing. In accordance with the Group Subscriber Agreement/Policy, Group is delegated to provide notice of termination to each subscriber/insured person at the subscriber's/insured person's current address. For nonpayment of premiums, UnitedHealthcare and Affiliates will send a notice of termination with appeal rights directly to the member.

The falsity of any statement in the application for any Policy/Group Subscriber Agreement shall not bar the right to recovery under the Policy/Group Subscriber Agreement unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer/health care service plan.

UnitedHealthcare disclosure regarding producer compensation: In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions, if applicable, are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established 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. Please note, we also make payments from time to time to producers for services other than those relating to the sale of policies/agreements (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be 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.

For specific information about the compensation payable with respect to your particular policy/agreement, please contact your producer.

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BINDING ARBITRATION

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN GROUP/COMPANY, MEMBERS AND ENROLLEES (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION BY A SINGLE NEUTRAL ARBITRATOR IN ACCORDANCE WITH THE COMMERCIAL RULES OF THE AMERICAN ARBITRATION ASSOCIATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO A COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE §1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. § 1 ET SEQ. IF A CLAIM FOR MEDICAL MALPRACTICE SEEKS TOTAL DAMAGES OF $50,000 OR LESS, THE CLAIM OR DISPUTE SHALL BE DECIDED BY A SINGLE NEUTRAL ARBITRATOR WHO SHALL HAVE NO JURISDICTION TO AWARD MORE THAN $50,000. IF THE PARTIES ARE UNABLE TO AGREE TO THE SELECTION OF A SINGLE ARBITRATOR, THE METHOD FOR THE APPOINTMENT OF THE ARBITRATOR IN CALIFORNIA CODE OF CIVIL PROCEDURE SECTION 1281.6 SHALL BE UTILIZED.

Authorized Signer for Group (Name Required)	Title (Required)
Signature (Required)	Date (Required)

Producer Information (if applicable)

Writing Producer Name				Writing Producer SSN		
Holds Current Appointment with ☐ UnitedHealthcare	Payee CA License #	Payee CA License Expiration Date		Writing Agent's License #	Writing Agent's License Expiration Date	
All Payments to		Payee Code	CRID Code	Tax ID#	If more than one Producer*, Split _____%	
Street Address		City			State	ZIP Code
Producer Phone #	Producer Fax Number			Producer Email Address		

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

Please Check One of the Following (Required):

☐ I attest that I assisted the applicant in submitting this application to UnitedHealthcare. To the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that, to the best of my knowledge, the applicant understood the explanation.

☐ I attest that I did not advise or assist the applicant whatsoever in providing answers or responses to any of the questions contained in the application.

IMPORTANT NOTICE: If you willfully state as true any material fact you know to be false, you are subject to a civil penalty of up to ten thousand ($10,000) pursuant to California Insurance Code Section 10119.3 and California Health and Safety Code Section 1389.8.

Producer Signature	Date

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

General Agent Information (if applicable)

General Agent	General Agent Tax ID#	Phone #	Franchise Code	
Street Address	City		State	ZIP Code
Contact Name	Email Address			

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