(DO NOT STAPLE)

Employer Application for Small Business

Maryland Groups with 1-50 Eligible Employees

UnitedHealthcare®

☐ Optimum Choice, Inc
10175 Little Patuxent Parkway, 6th Floor
Columbia, MD 21044

☐ UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103

☐ MAMSI Life and Health Insurance Company
10175 Little Patuxent Parkway, 6th Floor
Columbia, MD 21044

☐ UnitedHealthcare of the Mid-Atlantic, Inc.
10175 Little Patuxent Parkway, 6th Floor
Columbia, MD 21044

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.
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) | Internet Access? ☐Yes ☐No

Contact Person | Email Address | # of Years in Business

Billing Address (If Different) | Telephone | Fax

Multi-Location Group* ☐Yes ☐No | # Locations | Address(es) (or list on additional sheet of paper)

*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.

Organization Type ☐Partnership ☐C-Corp ☐S-Corp ☐LLC ☐LLP ☐Sole Proprietor ☐Other_____
Did you have any employees other than yourself and your spouse/domestic partner during the preceding calendar year? ☐Yes ☐No

Medical Benefit Plan Option ☐Calendar Year ☐Policy Year

Domestic Partner Coverage ☐Yes ☐No

Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days)
☐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

Classes Excluded: ☐None ☐Union ☐Hourly ☐Non-Management ☐Salary | Nature of Business | Industry (SIC) Code

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
☐By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company (PPO, POS) or UnitedHealthcare of the Mid-Atlantic, Inc. (HMO) or Optimum Choice, Inc. (HMO) or MAMSI Life and Health Insurance Company (EPO, PPO, POS)
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Group Name _____

General Information (continued)

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. For medical plans, if your employer has selected an HMO plan, you have a choice to enroll in an HMO plan or POS plan. The HMO plan only provides benefits when you use a network provider. The POS plan provides benefits for network and out-of-network providers. If your employer has selected an EPO plan, you have a choice to enroll in an EPO plan or PPO plan. The EPO plan only provides benefits when you use a network provider. The PPO plan provides benefits for network and out-of-network providers. Indicate the dollar amount selected for the Term Life and Accidental Death & Dismemberment (AD&D), Supplemental Term Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
# Hours per week to be eligible _____		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
For Disability products the minimum # of work hours per week to be eligible is 30 hours.		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
		LTD		LTD		LTD		
		Other		Other		Other		

☐Yes ☐No	Coverage provided to Full-time employees who work, on average, 30 hours per week.
☐Yes ☐No	Coverage provided to Part-time employees who work a normal work week of at least 17.5 hours.
☐Yes ☐No	**Subject to ERISA? (Most private sector plans are ERISA plans)** If No, please indicate appropriate category: ☐Church (Additional information needed) ☐Federal Government ☐Indian Tribe – Commercial Business ☐Non-Federal Government (State, Local or Tribal Gov.) ☐Foreign Government/Foreign Embassy ☐Non-ERISA Other

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 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. (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 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 on page 1).

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

Consumer Driven Health Plan Options

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

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 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

Answers must be accurate. For the HRA question, this statement applies whether purchased from UnitedHealthcare or any other insurer or third party administrator.

Group Name _____

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).
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) ☐ Taft Hartley Union ☐ Church ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Governmental ☐ 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.

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	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			
Current Vision Carrier	☐ None			

Group Name _____

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. This consent remains in effect until it is withdrawn. The Group may withdraw their consent at any time or request a document in a paper or non-electronic form.

I represent, to the best of my knowledge and belief, 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 intentional misrepresentation, fraudulent statement, or omission that constitutes fraud 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.

IT IS A CRIME TO KNOWINGLY PROVIDE, OR TO KNOWINGLY ASSIST, ABET, OR CONSPIRE WITH ANOTHER TO PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE THE COMPANY OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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 may pay "base commissions" based on factors such as product type, amount of premium, group/company 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 (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, please contact your producer.

Please note, that to the extent permitted by applicable State law, an employer's failure to pay any past-due premium amounts owed for coverage to this health insurer to whom you are applying for coverage, or any other health insurance company within this health insurer's control group, within the past 12 months preceding the requested effective date of any new coverage, will be assigned to the employer's initial premium payment and the prior premium debt owed will be considered paid first in line before the new policy premium amount in order to effectuate new coverage.

Signature

If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Customer Service Representative before signing this application.

Group Authorized Signature	Title	Date

Producer Information (if applicable)

Writing Producer Name	Writing Producer SSN		Is the Producer appointed with UHC? ☐ Yes ☐ No
All Payments to:	CRID Code (for internal use)	Tax ID	If more than 1 Producer*, Split _____ %
Street Address	City	State	Zip Code
Producer Phone #	Producer Email Address	Producer 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.	**Producer Signature**	**Date**

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

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Information (if applicable)

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

Point-of-Service Option Disclosure Statement

The following Point-of-Service Options Disclosure Statement applies to medical coverage that is provided initially to group members through an in-network only health maintenance organization (HMO). The Statement will apply if the Employer elects to offer its group members a "point-of-service option" that provides medical coverage out of the HMO's network of providers. The Statement does not apply if the Employer elects not to offer this additional benefit to its group members.

Under Maryland law, your group member may purchase a point-of-service option as an additional benefit. A point-of-service option allows your group members to obtain health care services from physicians and other providers outside the HMO network under certain circumstances that are described in the attached materials. You have the choice to either pay for this point-of-service option, pay a percentage of the cost of this option, or require your group members to pay for the entire cost of the option. The cost of this point-ofservice option described in the attached materials is identified in your proposal. Please indicate below the group members who have chosen this point-of-service option.

_____

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I have read and understand this disclosure statement and the attachments and have provided notice of the availability of this additional benefit to my eligible group members.

_____ _____

Date Enrolling Group Signature

Out-of-Network Option Disclosure Statement

The following Out-of-Network Options Disclosure Statement applies to medical coverage that is provided initially to group members through a Choice "in-network only" insurer. The Statement will apply if the Employer elects to offer its group members a Choice Plus "out-of-network option" that provides medical coverage out of the insurer's network of providers. The Statement does not apply if the Employer elects not to offer this additional benefit to its group members.

Under Maryland law, your group member may purchase an out-of-network option as an additional benefit. An out-of-network option allows your group members to obtain health care services from non-preferred providers under certain circumstances that are described in the benefit summary. You have the choice to either pay the cost of this out-of-network option, pay a percentage of the cost of this option, or require your employees to pay for the entire cost of the option. The cost of this out-of-network option described in the benefit summary is identified in your proposal. Please indicate below the group members who have chosen this out-of-network option.

_____

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I have read and understand this disclosure statement and the attachments and have provided notice of the availability of this additional benefit to my eligible group members.

_____ _____

Date Enrolling Group Signature