

Key Account Insured Employer Application



To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.
3. Include a deposit check in the amount of the estimated first month's premium; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

Requested Effective Date _____

To be completed by UnitedHealthcare Account Executive

Product Selection (i.e. Choice, Choice Plus, etc.) _____

Medical Benefit Plan Number _____ **Prescription Benefit Plan Number** _____

Quoted Rates

Product	_____	_____	_____
Employee	_____	_____	_____
Employee+Spouse	_____	_____	_____
Employee+Child(ren)	_____	_____	_____
Family	_____	_____	_____
Dual Option Identifier	<input type="checkbox"/> Yes <input type="checkbox"/> No	Overture Product	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Overture Package	_____

Ancillary Benefits

UnitedHealthcare Dental Yes No
 Dental Plan Code _____

Vision Benefits
 Standard Yes No
 Quality Yes No
 Elite Yes No

Life/AD&D Benefits _____ Yes No
 Dependent Life Yes No
 Dependent Life Plan Code _____

Supplemental Life Yes No
 Critical Illness Rider Yes No

General Information

Group Name _____

Street Address _____ Tax ID _____

City _____ State _____ Zip Code _____ County _____

Contact Person _____ Telephone () _____ Fax () _____

Billing Address (if different) _____ Email Address _____

Multi-location group? # of Locations _____ Address (please list locations on additional sheet)
 Yes No

Years in Business _____ Nature of Business _____ Industry Code _____

Number of employees/dependents currently on COBRA/Continuation _____ Total # Employees _____ # Full Time Employees _____ # Part Time Employees _____

Applying (Please include those employees in their waiting period) _____ # Waiving _____ # Hours per week to be Considered Eligible _____

Termined in 12 months _____ Wait Period for New Hires First of the Month Following _____ Days of Employment

Name of Current Medical Carrier _____ # Yrs with the Current Carrier _____ Name of Current Dental Carrier _____ # Yrs with the Current Carrier _____

Employer Contribution – Single _____% Medical Family _____%	Employer Contribution – Single _____% Life Dependent _____%	Employer Contribution – Single _____% Dental Family _____%	Classes <input type="checkbox"/> Union/Non Union Excluded <input type="checkbox"/> Other _____
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Worker's Comp Carrier _____ List Owners/Partners not covered by Workers Compensation _____

Yes No In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

Yes No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be placed voluntarily into bankruptcy?

Medical Profile

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.

- Yes No 1. Are any eligible employees or dependents receiving disability benefits of any type including Short Term Disability, Long Term Disability, Social Security Disability Income, Workers Compensation, Medicare, Medicaid or on extended leave due to injury, disability or illness?
- Yes No 2. Are any employees or dependents contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and/or surgery?
- Yes No 3. Have any eligible employees or dependents had large claims in excess of \$10,000, or do you anticipate any large claims?

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check One		Age	Date of Recovery	Date of Treatment/Condition	Nature of Medication	Name of Condition	\$ Amount of Claims	Prognosis Current Treatment
	Employee	Dependent							

The Company certifies that the information provided above is complete and accurate. Company shall notify the Insurer 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, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer 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 this Policy.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Company's employees.

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.

Upon receipt by UnitedHealthcare of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

*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 (Form must be signed)

Client Signature _____ Date _____ Title _____

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Broker Commission Data



Name of Group:	Effective Date:
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This document is to be completed as part of the Employer Application.

*See above for important disclosure regarding producer compensation.

Please indicate below the broker **OR** agency to whom commissions should be paid. ***If more than one broker or agency are to be paid, please indicate percentage in the space provided on the right*.***

1. Broker/Agency Information

Agent Code: _____

Include both broker and agency names, **but check only one box.**

Pay commissions to: _____
Broker/Agent Name Social Security # _____
* _____%

Pay commissions to: _____
Agency Name Federal Tax ID # _____

Is broker/agency appointed with UnitedHealthcare? Yes No

Signature: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Fax Number: _____ E-Mail Address: _____

2. Broker/Agency Information

Agent Code: _____

Include both broker and agency names, **but check only one box.**

Pay commissions to: _____
Broker/Agent Name Social Security # _____
* _____%

Pay commissions to: _____
Agency Name Federal Tax ID # _____

Is broker/agency appointed with UnitedHealthcare? Yes No

Signature: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Plan Use Only Group/Policy #:

UnitedHealthcare of Illinois, Inc. provides the following products:

- UnitedHealthcare Select
- UnitedHealthcare Select Plus

United HealthCare Insurance Company of Illinois provides (for Illinois employers only):

- UnitedHealthcare Open Access

United HealthCare Insurance Company of Illinois (for Illinois employers only) and United HealthCare Insurance Company both provide:

- UnitedHealthcare Choice Plus
- UnitedHealthcare Select Plus
- UnitedHealthcare Options PPO
- UnitedHealthcare Options PPO 80/80
- UnitedHealthcare Managed Indemnity
- UnitedHealthcare Overture
- [UnitedHealthcare Rhapsody]
- UnitedHealthcare Dental Managed Indemnity
- UnitedHealthcare Dental Options PPO

Dental Benefits Providers, Inc., and affiliates provide UnitedHealthcare Dental Select DHMO