

New Group Checklist 2-50 Eligible Employees

Thank you for your new group submission. The following pieces of information are required when submitting a new case to UnitedHealthcare.

Group Name _____

- A **check** in the amount of the first month's premium (approximate amount is acceptable) *payable to: UnitedHealthcare of Illinois, Inc.*
- Completed UnitedHealthcare **Illinois Small Business Employer Application**.
- Copy of the most recent **billing statement** from the current carrier.
- Copy of the most recent **Quarterly Wage & Tax Statement** (employee roster portion). Indicate status of all employees listed (full-time, part-time, terminated, etc.) **In lieu of the most recent Quarterly Wage & Tax Statement, the following is needed if you are:**
 - "C" Corporation - Articles of Incorporation, Form 1120, current wage and tax or current payroll records.
 - "S" Corporation - Articles of Incorporation, Form 1120S, K-1s on owners/partners, current wage and tax or current payroll records. (Only the shareholders of an S Corporation may collect dividends as all or a part of their wages.)
 - Partnership - Partnership agreement, Form 1065 and K-1s on the partners of the partnership, current wage and tax or current payroll records (if employees are not partners). Only the partners of a partnership can take a draw from the company and still be considered an eligible employee.
 - Sole Proprietorship - Business license (if in business less than one year and a Schedule C has not been filed yet) or Schedule C, and current payroll records for employees other than the owner. Only the owner of a sole proprietorship can take a draw from the company and still be considered an eligible employee.
 - Limited Liability Company (LLC) - LLC agreement; Either C Corporation or Partnership documentation (see above).
 - Church - Form 941 and current payroll records.
 - Farm - Schedule F; current payroll records.

Individual enrollment application forms for all eligible employees: Medical History section is required for all medical and/or life applicants, including employees in a waiting period. Please make sure all applications are signed and dated.

Send your new case submission to your UnitedHealthcare Account Executive or General Agency.

Please note: The UnitedHealthcare Medical Underwriting Department reserves the right to request different or additional documents as they deem necessary.

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 and current status.
- 4 Submit most recent wage and tax information.
- 5 Include a deposit check for the first month's premium.
- 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)

--	--

Address	Tax ID
---------	--------

City	State	Zip Code	County	Names of Owners/Partners (if applicable)
------	-------	----------	--------	--

Contact Person	Telephone	Fax	Email Address
----------------	-----------	-----	---------------

Billing Address (If Different)	# of Years in Business
--------------------------------	------------------------

Organization Type	Partnership	C-Corp	S-Corp	LLC/LLP	Nature of Business	Industry Code
Ind. Contractor	Non-Profit	Sole Proprietor	Other			

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

# Hours per week to be eligible	Waiting Period for new hires	1st of Policy Month following Date of Hire 1st of Policy Month following ___ months of employment Date of Hire (no waiting period) ___ months of employment following Date of Hire	Waiting Period waived for initial enrollees Yes No
---------------------------------	------------------------------	---	--

Have Worker's Comp	Worker's Comp Carrier Name	Names of Owners/Partners not covered by Workers' Comp:
Yes No		

Names of Persons currently on COBRA/Continuation: See Attached List None	Classes Excluded: None Union Hourly Non-Management Non-Owners
---	--

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

Name of Current Medical Carrier	Begin Date ___/___/___	Name of Current Dental Carrier	Begin Date ___/___/___
None	End Date ___/___/___	None	End Date ___/___/___

Participation	# Applying for:	# Waiving for:	Contribution	Employer %	Employee%	Employer % for Dep
# Full Time Employees	Medical	Medical	Medical			
# Part Time Employees	Life	Life	Life			
# Ineligible Employees	Dental	Dental	Dental			
Total # Employees	Vision	Vision	Vision			
	Other	Other	Other			

Questions Regarding Group Size

COBRA St. 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 of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
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. Check one.
Yes No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each.

Coverage provided by "UnitedHealthcare and Affiliates":
 Medical/Dental coverage provided by UnitedHealthcare of Illinois, Inc., United HealthCare Insurance Company of Illinois,
 or United HealthCare Insurance Company
 Life Insurance coverage provided by United HealthCare Insurance Company
 Vision coverage provided by United HealthCare Insurance Company

Please Continue On The Back Side Of This Form

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.

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, and that any misrepresentation or fraudulent statement 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.

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.

UnitedHealthcare disclosure regarding producer compensation: 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

Group Signature	Title	Date
-----------------	-------	------

Commission Information

Writing Broker Name	Writing Broker SSN			Is the Broker appointed with UHC? Yes No
Commissions Payable to:	Payee Code	CRID Code	Tax ID#	If more than 1 Broker, Split _____%
Street Address	City		State	Zip Code
Broker Phone #	Broker Email Address		Broker 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.

Broker Signature	Date
------------------	------

For the Second Broker / Agent (if Applicable)

Writing Broker Name	Writing Broker SSN			Is the Broker appointed with UHC? Yes No
Commissions Payable to:	Payee Code	CRID Code	Tax ID#	If more than 1 Broker, Split _____%
Street Address	City		State	Zip Code
Broker Phone #	Broker Email Address		Broker 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.

Broker Signature	Date
------------------	------

General Agent Override Information

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

Admin Kit

Send Admin Kit To:	Address
--------------------	---------

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

Confidentiality

Make sure your employer has completed the “To be completed by the employer” section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



Your rights and responsibilities



Important information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete, and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at myuhc.com[®].

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do

we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Pre-existing conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.

I authorize any required premium contributions to be deducted from earnings.

Scheduled Direct Debit Authorization Form

Enrollment Instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.

STATEMENT OF UNDERSTANDING

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

It may take up to one month to establish this process. If a customer is overdue on a prior bill, a delinquency letter will be sent to the customer, and must be paid to ensure the account is not cancelled prior to the process being set up.

I authorize UnitedHealthcare to debit my group's checking or savings account for all monthly charges for coverage.

I ensure sufficient funds are in my group's checking or savings account to cover my premium invoice.

If the necessary funds are not on deposit in the account at the beginning of the month, my group's coverage may be subject to termination under the terms stated in the contract with UnitedHealthcare. Also, my group may be subject to additional fees incurred by UnitedHealthcare subsequent to the termination date as a result of insufficient funds.

I will promptly notify UnitedHealthcare of any change to my group's checking or savings account. If a change occurs it is my responsibility to provide UnitedHealthcare with the current information.

AUTHORIZATION

I hereby authorize UnitedHealthcare to initiate debits (payments) to the financial institution indicated below for the purpose of paying my group's monthly bill. This financial institution is authorized to debit my account. This authority is to remain in full force and effect until either my group revokes it by giving 30 days prior written notice to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above, or upon termination of my group's coverage with UnitedHealthcare. I have also read and, on behalf of my group, agree to the terms and conditions outlined above.

Authorized Signature

Date

Employer Name/Customer Name/Policy Name

Employer Email Address

Customer Number and Bill Group(s)

Name of Your Financial Institution and Location State

Phone Number of Financial Institution

Transit / American Bankers Association #

Number can be found in lower left corner of your check

Account Number to Debit

Debits to your account will be made on the beginning of each month

Employer eServices

Becoming a UnitedHealthcare customer has its privileges!

As a UnitedHealthcare customer, the group contact listed on the Employer Group Application will automatically be enrolled in Employer eServices and emailed a User ID and Password. The Employer eServices Web site provides easy access to benefit administration, with 24 hour convenience to make benefit management simpler, easier and better!

With Employer eServices, you have real-time administration to:

- Verify eligibility
- Review enrollment information
- Add employees and dependents
- Change eligibility
- Reinstate employees
- Terminate employees
- Request employee ID cards
- Select or Change Primary Care Physician (as required by plan)
- Delegate benefits administration work to additional staff

Once you receive your User ID and Password, simply go to www.employereservices.com.

We believe in putting the power of information into the hands of our customers!

Product and Benefit Selection Form for Small Business



Group Name _____

Effective Date Requested _____

1. Single Option Medical Plan & Rx Selection. *Example 7AA w/2V* Plan _____ Rx _____
 Dual Option If taking Dual Option, please specify the two plans & Rx: _____ & _____
 Multi-Site List all other locations _____

1a. Are you enrolling in Health Savings Account (HSA)? Yes No

1b. Are you enrolling in a Health Reimbursement Account (HRA)? Yes No

- 1c. Deductible Administration
 Calendar Year (from Jan. 1 to Dec. 31)
 Policy or Contract Year (from effective date to renewal date)

2. Dental Plan Selection(s) 3a. Has this group been covered for major dental services for the previous 12 consecutive months?
 _____ Yes No If yes, name of carrier _____

3. Vision Plan Selection(s)

4. Supplemental Coverage(s)	Benefit Description
Life / AD&D <input type="radio"/> Yes <input type="radio"/> No	_____
Dependent Life <input type="radio"/> Yes <input type="radio"/> No	_____
STD <input type="radio"/> Yes <input type="radio"/> No	_____
LTD <input type="radio"/> Yes <input type="radio"/> No	_____

5. Optional Medical Rider(s)
- 24 Hour Coverage (At occupation coverage)
 - Infertility
 - Other (Please list)
- _____
- _____

6. Other Notes

Signature			
Employer Signature	Title	Date	

Employee Enrollment Form

Groups with 2-50 Employees

Used tobacco in the last 12 months? Yes No

B. Family Information List All Enrolling (Attach sheet if necessary)

Last Name	First Name	MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (First and Last Name)	Tobacco Used
Social Security Number			M	Spouse						Yes
			F		No					
			M	Dependent				Yes		Yes
			F		No	No				
			M	Dependent				Yes		Yes
			F		No	No				
			M	Dependent				Yes		Yes
			F		No	No				
			M	Dependent				Yes		Yes
			F		No	No				

*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents, for UnitedHealthcare Select, Select Plus, and other products requiring a Primary Physician designation only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

C. Product Selection					Please check all that apply. Benefit offerings are dependent upon employer selection.				Dual Option Plan Selected
Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Life Insurance Beneficiary's Full Name and Address									Relationship

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical/Dental coverage provided by UnitedHealthcare of Illinois, Inc., United HealthCare Insurance Company of Illinois, or United HealthCare Insurance Company
 Life Insurance coverage provided by United HealthCare Insurance Company
 Vision coverage provided by United HealthCare Insurance Company



D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? YES (continue completing this section) NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.
 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

Medicare – Spouse/Dependent Name: _____
 Enrolled in Part A: Effective Date _____ Ineligible for Part A* Not Enrolled in Part A (chose not to enroll)
 Enrolled in Part B: Effective Date _____ Ineligible for Part B* Not Enrolled in Part B (chose not to enroll)
 Enrolled in Part D: Effective Date _____ Ineligible for Part D* Not Enrolled in Part D (chose not to enroll)
 Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Medical History

Employee Name _____ SSN _____ Group Name _____

Has anyone on this application consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.**

1 Cancer Yes No	Breast Testicular Colon Brain Leukemia Ovarian Lymphoma Cervical Liver Prostate Lung Stage _____ Melanoma Other _____
2 Heart/Circulatory Yes No	Aneurysm Heart Disease Blood Disorder Bypass High Blood Pressure Sickle Cell Anemia Angioplasty/Stent Stroke Other _____ Congestive Heart Failure Angina Hemophilia Elevated Cholesterol/Triglycerides Blood Clots Pacemaker
3 Reproductive Yes No	Current Pregnancy (due date _____) Multiples (# _____) Pregnancy Complications Fibroids Menstrual Disorders Breast Disorders Endometriosis Infertility Other _____
4 Intestinal/Endocrine Yes No	Chronic Pancreatitis Hepatitis B/C Colon Disorder Reflux Crohn's Ulcer Ulcerative Colitis Growth Hormones Diabetes Cirrhosis Other _____
5 Brain/Nervous Yes No	Alzheimer's Disease Parkinson's Disease Cerebral Palsy Tumor Migraines Head Injury Multiple Sclerosis Cyst Paralysis Seizures/Epilepsy Other _____
6 Immune Yes No	Scleroderma ALS Rheumatoid Arthritis Psoriasis AIDS HIV+ Lupus Immuno Deficiency Other _____
7 Lung/Respiratory Yes No	Allergies Asthma Cystic Fibrosis Emphysema Sarcoidosis Lung Disorders Tuberculosis Sleep Apnea Other _____
8 Eyes/Ears/Nose/Throat Yes No	Acoustic Neuroma Deviated Septum Cataracts Glaucoma Cleft Lip/Palate Retinopathy Other _____
9 Urinary/Kidney Yes No	Chronic Kidney Stones Prostate Disorder Kidney Disorders Renal Failure Bladder Disorders Polycystic Kidney Disease Other _____
10 Bones/Muscles Yes No	Osteoarthritis Knee Disorder Bulging/Herniated Disc Spina Bifida Joint injury Back Disorder Fibromyalgia/CFS Neck Disorder Shoulder Disorder Other _____
11 Behavioral Health Yes No	Anxiety/Depression Suicide Attempt ADHD Inpat ETOH/Drug Bipolar/Manic Depression Inpat MH Hosp Schizophrenia Autism Eating Disorder Other _____
12 Transplant Yes No	Bone Marrow Transplant Organ Complications Discussed Possible Future Transplant Year _____ Stem Cell Other _____
13 Medication Yes No	Current Medications Please List Meds _____ Medications Taken Within The Past Year Please List Meds _____

(continued on next page)

E. Medical History (continued)

14 Other Yes No	Abnormal Test Or Physical Results	Condition Not Mentioned Above	
	Treatment Or Surgery Discussed Or Advised	Pending Test Results	Inpat Hosp/Surg in Past Yr.
	Pending w/c claim	Tests Advised or Recommended	Refer to Specialist

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

F. Waiver of Coverage I decline coverage for: Myself Spouse Dependent Children Myself and all dependents	Declining coverage due to existence of other coverage: Spouse's Employer's Plan Covered by Medicare COBRA from Prior Employer Tri-Care I (we) have no other coverage at this time Other _____	Individual Plan Medicaid VA Eligibility	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.	Employee Initials	Date

G. Signature

I authorize the Company and Affiliates to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying UnitedHealthcare and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)
------	---	---

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

- Race, check all that apply:

<input type="checkbox"/> White	<input type="checkbox"/> Black, African-American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Other Race, please specify _____		
- Are you of Hispanic or Latino origin? Yes No

I authorize any required premium contributions to be deducted from earnings.

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

CONFIDENTIALITY

Make sure your employer has completed the "To be completed by the employer" section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



guide

Your Rights and Responsibilities



Important Information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at www.myuhc.com.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:

We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.

We do not decide what care you need or will receive. You and your physician make those decisions.

2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not

control nor do we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Pre-Existing Conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30

days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.