Employer Application for Large Group

Wyoming

UnitedHealthcare®

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 any required premiums; 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.

General Information

Requested Effective Date _____

Group's/Company'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/company?* ☐Yes ☐No | # of Locations | Address(es) (or list on additional sheet of paper)

Organization Type ☐Partnership ☐C-Corp ☐S-Corp ☐LLC ☐LLP ☐Sole Proprietor ☐Other | Nature of Business | Industry Code

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 | Medical Benefit Plan Option ☐Calendar Year ☐Policy Year

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents) | Number of Employees Termed in last 12 Months | Classes Excluded: ☐None ☐Union ☐Hourly ☐Non-Management ☐Salary

Have Workers' Comp? ☐Yes ☐No | Name of Workers' Compensation Carrier | Domestic Partner Coverage? ☐Yes ☐No

Names of Owners/Partners not covered by Workers' Compensation

*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.

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 EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
		Basic Dep Life		Basic Dep Life		Basic Dep Life		
# Hours per week to be eligible for Disability coverage if different from above ** _____		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD		STD		STD		
		STD Buy Up***		STD Buy Up***		STD Buy Up***		
		LTD		LTD		LTD		
***Only available to Groups with 100+ Eligible Employees		LTD Buy Up***		LTD Buy Up***		LTD Buy Up***		
		Voluntary AD&D***		Voluntary AD&D***		Voluntary AD&D***		
		Other		Other		Other		

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
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)

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 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 _____

☐Yes ☐No In the past 36 months, has the Group/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 Group/Company or any affiliated entity be placed voluntarily into bankruptcy?

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

☐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 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 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.

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 the 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 on page 1).

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

HRA and Supplemental Insurance Information

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

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

Group Name _____

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? ☐Yes ☐No

Who will provide account balances to UnitedHealthcare?

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			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

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. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

☐Yes ☐No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

☐Yes ☐No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

☐Yes ☐No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

☐Yes ☐No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

☐Yes ☐No 6. Is any employee or dependent currently hospitalized?

☐Yes ☐No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?

- ☐Cancer (any type)
- ☐Lung disease or respiratory problem (any type)
- ☐Heart disease or disorder (any type)
- ☐Organ, tissue or cell transplant
- ☐Liver disease (any type)
- ☐Kidney disease (any type)
- ☐Pancreatic disorder (any type)
- ☐Diabetes
- ☐Hepatitis
- ☐Morbid obesity
- ☐Congenital abnormality
- ☐Vascular disease (any type)
- ☐Neurological disorder (any type)
- ☐Immunological disorder (reportable types)
- ☐Alcohol or drug addiction or abuse
- ☐Hemophilia or Blood disorder (any type)

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

Group Name _____

Disclosures (continued)

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

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates 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, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates 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 the policy/policies for which application is being made.

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 intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, 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 benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company'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.

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, or conceals information for the purpose of misleading, in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Upon receipt by UnitedHealthcare and Affiliates 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.

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 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 (Form must be signed)

Group/Company Signature_____ **Date**_____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Group Name _____

Producer Information (if applicable)

Producer Name	Agency	Agent Code/Tax ID Number

Email Address	Social Security #	Phone Number

All Payments to:	Producer Commission Schedule (if applicable) _____ Std Scale of _____ %

Street Address	City	State	Zip Code

Producer Signature	Date

Rep Name	Rep #

General Agent Information (if applicable)

General Agent	Phone #	Franchise Code	

Street Address	City	State	ZIP Code