CALIFORNIA

Employer Application for Key Accounts

UnitedHealthcare®

To avoid processing delays, please make sure you:
1. Answer all questions completely and accurately.
2. Include a deposit check for any required premiums.

Unimerica Life Insurance Company

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

Effective Date _____

General Information

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

Organization Type: ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Non-Profit ☐ Sole Proprietor ☒ Other _____	Nature of Business	Industry (SIC) Code

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

Names of affiliated/subsidiary firms whose employees are going to be covered	Do you cover early retirees? ☐ Yes ☒ No

#of hours per week to be eligible	Classes Excluded: ☐ None ☐ Union ☐ Hourly (# of hours_____) ☐ Non-Management ☐ Non-Owners	Waiting Period for New Hires ☐ 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	Waiting Period for Rehire ☐ Same as New Hire ☒ No Wait	Waiting Period Waived for Initial Enrollees ☐ Yes ☐ No

Employees terminate on ☐ Last day of month following date of termination ☒ Date of Termination	Open Enrollment from _____to _____
Dependent coverage up to age _____ (standard is 19)	Dependent Student coverage up to age _____(standard is 25)
Have Workers' Comp ☐ Yes ☐ No	Workers' Comp Carrier Name
Subject to ERISA Regulation ☐ Yes ☒ No	Are you subject to a local living wage law? ☐ Yes ☐ No

Is this business currently in Chapter 11 or currently being petitioned for bankruptcy or filed for bankruptcy within the last 36 months? ☐ Yes ☐ No

Premium Payment Options: ☐ Standard ☐ Alternate Payment Schedule
Note: Alternate payment schedule must be approved by UnitedHealthcare. Additional charges will apply.

Names of persons currently on COBRA/Continuation (attach additional sheet, if needed):

Name	☐COBRA ☒Cal-COBRA ☐Cal-COBRA-AB1401 ☐ Extended/Disabled COBRA	Qualifying Event	Date of Qualifying Event _____
Name	☒COBRA ☐Cal-COBRA ☐Cal-COBRA-AB1401 ☐ Extended/Disabled COBRA	Qualifying Event	Date of Qualifying Event _____
Name	☐COBRA ☐Cal-COBRA ☒Cal-COBRA-AB1401 ☐ Extended/Disabled COBRA	Qualifying Event	Date of Qualifying Event _____

Definitions of COBRA, Cal-COBRA, and Cal-COBRA-AB1401:
COBRA: Employed 20 or more total employees on at least 50% of the working days in the previous calendar year.
Cal-COBRA: Employed 2–19 eligible employees on at least 50% of its working days in the previous calendar year, or if not in business during any part of the previous calendar year, employed 2–19 eligible employees on at least 50% of its working days during the previous calendar quarter.
Cal-COBRA-AB1401: Additional 18-month extension of federal COBRA. The maximum period under COBRA and Cal-COBRA-AB1401 cannot exceed 36 months.

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Group Name _____

General Information (continued)

Name of Current Medical Carrier
Policy # _____ Coverage Dates _____ - _____

Name of Current Dental Carrier
Policy # _____ Coverage Dates _____ - _____

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

Leave of Absence
How long do you continue paying health care premiums for employees on leave of absence? (maximum of 6 months) _____

Name of other employer-sponsored group medical plan(s) _____

Number of employees enrolling under another group medical plan(s) sponsored by employer _____

Participation		Total Employees Applying for:		Total Employees Waiving:	
# of Full Time (30 + Hours) Employees		Medical		Medical	
# of Employees in Waiting Period		Dental		Dental	
# of Ineligible Employees (other than noted above)		Vision		Vision	
# of Total Employees		Life / AD&D		Life / AD&D	
# of Total Eligible Employees		Other		Other	
# of COBRA Participants					
# of Early Retirees					

Medical Disclosures

In order to evaluate an application properly, we require the employer to answer the questions below. Please answer each question to the best of your knowledge with respect to all eligible employees and dependents who you intend to have coverage under the plan, including those who will be on continuation of benefits under COBRA or other state continuation program.

1. Are you aware of any employee or dependent having been diagnosed or treated for any of the following conditions in the past three years?

a. Cardiac disorder	☐ Yes	☐ No	g. Kaposi's sarcoma	☐ Yes	☐ No
b. Cancer (any form)	☐ Yes	☐ No	h. Pneumocystis pneumonia	☐ Yes	☐ No
c. Diabetes	☐ Yes	☐ No	i. Psychological disorders	☐ Yes	☐ No
d. Kidney disorder	☐ Yes	☐ No	j. Neuromuscular disorder	☐ Yes	☐ No
e. Respiratory disorder	☐ Yes	☐ No	k. Transplant candidate	☐ Yes	☐ No
f. Liver disorder	☐ Yes	☐ No	l. Alcohol/Drug abuse	☐ Yes	☐ No

2. Are you aware of any employee or dependent who is currently disabled or receiving ongoing care for a medical disability? ☐ Yes ☐ No

3. Are you aware of any employee or dependent who is currently hospitalized or who is anticipating hospitalization or surgery within the next 60 days? ☐ Yes ☐ No

4. Are you aware of any employee who has missed more than 10 consecutive days of work in the past 12 months due to illness or injury? ☐ Yes ☐ No

5. Has any employee or dependent accumulated medical claims in excess of $25,000 in the past 12 months? ☐ Yes ☐ No

6. Are you aware of any employee or dependent who is currently pregnant? If yes, how many? _____ ☐ Yes ☐ No

7. Are you aware of any employee who has an autistic or otherwise psychiatrically disabled dependent? ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, then please provide the additional information requested below for each individual. Please attach additional sheet if necessary.

Indicate whether employee/dependent	Nature of Illness	Date of Onset	Approximate Amount of Claim	Length of Disability	Current Health Status
☐ Employee ☐ Dependent		/ /	$		
☐ Employee ☐ Dependent		/ /	$		
☐ Employee ☐ Dependent		/ /	$		

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Group Name ______________________________

Tier Structure Requested (check one only): ☑ **1 Tier** ☐ **2 Tier** ☐ **3 Tier** ☐ **4 Tier**

Product Selection / Rates by Tier

Product Selection		Rates/Tier	Contrib % / $ Emp / Dep
Medical Plan Description ____________ Behavioral Plan Type (Mandatory for HMO) ________ Rx Plan Description ____________ **Optional Riders** Description____________ Description____________ Description____________	Medical Plan Code ________ Custom Plan (Attach Description) Rx Plan Code________ Plan Code ________ Plan Code ________ Plan Code ________	1. 2. 3. 4.	1. 2. 3. 4.
Medical Plan Description ____________ Behavioral Plan Type (Mandatory for HMO) ________ Rx Plan Description ____________ **Optional Riders** Description____________ Description____________ Description____________	Medical Plan Code ________ Custom Plan (Attach Description) Rx Plan Code________ Plan Code ________ Plan Code ________ Plan Code ________	1. 2. 3. 4.	1. 2. 3. 4.
Medical Plan Description ____________ Behavioral Plan Type (Mandatory for HMO) ________ Rx Plan Description ____________ **Optional Riders** Description____________ Description____________ Description____________	Medical Plan Code ________ Custom Plan (Attach Description) Rx Plan Code________ Plan Code ________ Plan Code ________ Plan Code ________	1. 2. 3. 4.	1. 2. 3. 4.
Dental Plans Plan 1 Description____________	Dental Plan Code ________	1. 2. 3. 4.	1. 2. 3. 4.
Dental Plans Plan 1 Description____________	Dental Plan Code ________	1. 2. 3. 4.	1. 2. 3. 4.
Vision Plans Plan 1 Description____________	Vision Plan Code________	1. 2. 3. 4.	1. 2. 3. 4.

Group Term Life and AD&D Insurance

Life/AD&D Benefits Flat Amount $________ or Multiple of Salary ________ x Annual Salary to $________ or Scheduled Plan

Life Rate per $1,000 $ ______ AD&D rate per $1,000 $ ______	Contribution % Employee ________ Dependent ________	Class 1 $ ______ Title ____________ Class 2 $ ______ Title ____________ Class 3 $ ______ Title ____________

Dependent Life Benefit Amount
Spouse $ ______ Child (14+ days) $ ______ Dependent Life rate / unit $ ______

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Important Information

I certify that the information provided above is complete and accurate. I 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, I 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(ies)/agreement 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 health plan coverage/insurance benefits. **I understand that intentional material misrepresentations or intentional material omissions may result in rescission of the group policy/agreement, termination of coverage, or increase in premiums retroactive to the original effective date of the agreement/policy. Rescinding coverage means that the Agreement/ Policy and Evidence of Coverage/Certificate of Coverage (EOC/COC) are void and that no coverage existed at any time. UnitedHealthcare will issue a written notice to the group/company including the cause for termination and appeal rights.** The Group/Company will receive any notices for failure to pay and/or termination in writing. In accordance with the Group Subscriber Agreement/Policy, the Group/Company 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.

Any person who knowingly and with intent to defraud any insurance company/health care service plan or other person files an application for insurance/health plan coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance or health plan coverage act, which is a crime.

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

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 or hard copy to enrolled members in accordance with California and federal laws, so as to afford the enrollee full and fair disclosure.

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/health plan coverage 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/agreements (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 pursuant to as required by federal law. 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 arrangement, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy/agreement, please contact your producer.

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 OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATIONS BY A SINGLE NEUTRAL ARBITRATOR IN ACCORDANCE WITH THE COMMERCIAL RULES OF THE AMERICAN ARBITRATION ASSOCIATION. ANY SUCH DISPUTE WILL NOT BE

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Group Name _____

BINDING ARBITRATION (continued)

RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THE AGREEMENT ARE GIVING UP THEIR CONSTITUTIONS 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 SECTION1280 ET. SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDED INCLUDING BUT NOT LIMITED TO THE FEDERAL ARBITRATION ACT, 9 U.S. C. SECTION1 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 ARBITRATION IN CALIFORNIA CODE OF CIVIL PROCEDURES SECTION 1281.6 SHALL BE UTILIZED.

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

Authorized Signatures

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.

Authorized Signer for Group (Name / Title)	Signature		Date ____ / ____ / ____
Writing Agent Signature			Date ____ / ____ / ____
UnitedHealthcare Representative (Name / Title / Phone#) / /	Signature	Rep #	Date ____ / ____ / ____
Underwriter Name	Date Reviewed _____ / _____ / _____	Application Disposition: ☐ Approved ☐ Declined ☐ Re-rated	

Broker Information

Writing Agent Name		
Writing Agent SSN or TIN	Writing Agent License #	Writing Agent License Expiration Date _____ / _____ / _____
Holds Current Appointment With: ☐ UnitedHealthcare		WA CRID Code
Address	City, State	Zip Code
Phone	Fax	E-mail

If more than 1 Writing Agent*, Split commission as follows:
Name: _____ at _____ % and Name: _____ at _____%
* If more than 1 Writing Agent, provide the second Agent's information on an additional sheet of paper.

Commissions payable to: ☐ Writing Agent ☐ Firm	Firm Name	
Firm TIN	Firm License #	Firm License Expiration Date _____ / _____ / _____
Holds Current Appointment With: ☐ UnitedHealthcare		Firm's CRID Code
Address	City, State	Zip Code
Phone	Fax	E-mail

Coverage provided by "UnitedHealthcare and Affiliates": Medical coverage provided by United HealthCare Insurance Company. Dental coverage provided by United HealthCare Insurance Company, Unimerica Life Insurance Company or Dental Benefit Providers of California, Inc. Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Life Insurance Company. Vision coverage provided by United HealthCare Insurance Company or Unimerica Life Insurance Company. Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by PacifiCare Health Plan Administrators, Inc., Prescription Solutions or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

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Additional Location Addresses:

The second Agent's information

Writing Agent Name:

Writing agent SSN or TIN:

Writing agent license #:

Writing agent license expiration date:

Writing agent holds appointment with UnitedHealthcare? ☐ UnitedHealthcare

WA CRID code:

Additional names of persons currently on COBRA/Continuation:

Name	Type Of Coverage	Qualifying Event	Date Of Qualifying Event