Employer Application

Group Dental Coverage and
Group Vision Care Insurance
Provided by UnitedHealthcare Insurance Company

UnitedHealthcare®

Requested Effective Dates of Coverage: / /
Requested Policy Anniversary Date: / /
(All effective dates must be first of the month.)

GENERAL INFORMATION

Group's Full Legal Name:
Include names of subsidiaries or affiliated companies

Street Address:

City:	State:	Zip Code:
Contact Name:		Phone Number:
Fax Number:	E-Mail Address of Contact:	

Billing Address (If Different):

Organization Type: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Political Subdivision ☐ Other

Multi Location Group? ☐ Yes ☐ No	Number of Locations:	Locations:

Nature of Business:	Industry Code:
Employer Identification Number (Tax Id Number)	Subject to ERISA? ☐ Yes ☐ No If yes, ERISA plan number:

DENTAL PLAN PARTICIPATION AND SELECTION

Did the group have dental coverage for the past consecutive [12] months? ☐ Yes ☐ No
If yes, name of prior dental carrier and dates of coverage:

# Hours per week to be eligible:	Benefit Waiting Period for New Hires: ☐ Date of event following _____ months of employment ☐ 1st of policy month following _____ months of employment

Benefit Waiting Period Waived for Initial Enrollees: ☐ Yes ☐ No	Total Number of Employees on Payroll:	Total Number of full time/ eligible Employees:
Number of COBRA participants in total group:	Number of Retirees in total group: (applicable to groups of over 50 eligible subscribers)	
Will employees retired by the Employer be eligible for coverage? ☐ Yes ☐ No	If yes, specify groups eligibility:	

Dental Plan Selected:

Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	Employee				
Two Tier	Employee				
	Family				
Three Tier	Employee				
	Employee + One				
	Family				
Four Tier	Employee				
	Employee + One				
	Employee + Children				
	Family				
		Amount of Binder Check: *** This check must accompany the Group Application			

VISION PLAN PARTICIPATION AND SELECTION

# Hours per week to be eligible:	Benefit Waiting Period for New Hires:	☐ Date of event following _____ months of employment ☐ 1st of policy month following _____ months of employment ☐ Other:

Benefit Waiting Period Waived for Initial Enrollees: ☐ Yes ☐ No	Total Number of Employees on Payroll:	Total Number of full time/ eligible Employees:

Number of COBRA participants in total group:	Number of Retirees in total group: (applicable to groups of over 50 eligible subscribers)

Will employees retired by the Employer be eligible for coverage? ☐ Yes ☐ No	If yes, specify groups eligibility:

Premiums and Contributions

Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Employee Only				
Employee + One				
Employee + Spouse				
Employee + Children				
Employee + Family				
Composite				

Total Estimated Monthly Premium $

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If my coverage is approved, premium is payable monthly in advance.

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 the Company 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, or other consequences as permitted by law.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

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.

United HealthCare Insurance Company 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.

FRAUD WARNING NOTICE:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

GROUP SIGNATURE (form must be signed)	
Group Authorized Person's Name:	Title:
Group Authorized Person's Signature:	Date:

AGENT/BROKER INFORMATION		
Agent/Broker Name:		Agency:
Agent/Broker Signature:		Date:
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:
Commissions Payable To:		Agent/Broker Number:

[UnitedHealthcare Dental] and [Spectera] vision insurance products are underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut.