UnitedHealthcare Insurance Company
Administrative Office
9900 Bren Road East, Minnetonka, MN 55343

APPLICATION FOR GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, SHORT TERM DISABILITY, LONG TERM DISABILITY, ACCIDENT, and HOSPITAL INDEMNITY INSURANCE POLICY

A. GENERAL INFORMATION

1. FULL LEGAL NAME OF EMPLOYER: ____________________
2. STREET ADDRESS: (City, County, State, Zip Code) ____________________
3. FORM OF ORGANIZATION: ☐ Corporation ☐ Association ☐ Proprietorship ☐ Partnership
4. LIST ALL SUBSIDIARIES to be included: ____________________
5. EFFECTIVE DATE: ____________________
6 TAX ID NUMBER: ____________________ NATURE OF BUSINESS: ____________________
7. EMPLOYER PHONE NUMBER: ____________________ EMPLOYER FAX NUMBER: ____________________
   EMPLOYER E-MAIL ADDRESS ____________________

The Effective Date of the insurance is subject to approval of this application by UnitedHealthcare Insurance Company.

B. TYPE OF INSURANCE ELECTED

	Yes	No	No. of Eligible Employees	Percent of Employee Contribution
Basic Life Insurance				
Basic AD&D Insurance				
Supplemental Life Insurance				
Supplemental AD&D Insurance				
Dependent Basic Life Insurance				
Dependent Basic AD&D Insurance				
Dependent Supplemental Life Insurance				
Dependent Supplemental AD&D Insurance				
Short Term Disability				
Long Term Disability				
Accident Insurance				
Hospital Indemnity Insurance				

C. ADDITIONAL INFORMATION

1. Deposit submitted with application: ____________ If the policy is issued, the deposit will apply towards the first month's premium.
2. Will all or part of this policy replace similar coverage? Yes ☐ No ☐
   If Yes, show Carrier(s), Policy Numbers and Termination Dates: ____________________

D. AGREEMENT

The Employer and UnitedHealthcare Insurance Company ("we", "us" or "our") agree that:

THE APPLICATION shall form the basis for and become part of any policy issued.

PREMIUM RATES shall: (1) be subject to all provisions in that policy; and (2) be binding on both Employer and us.

LIABILITY OF THE COMPANY: We will have no liability until this request has been approved at Our Administrative Office.

AUTHORITY OF AGENTS: No agent can change the terms of this request or any policy We issue. No agent can waive any of our rights or requirements or extend the time for any premium payments.

CHANGES AND CORRECTIONS: The acceptance of any policy issued on this request shall constitute ratification of any correction or amendment made by Us. Changes are an amendment to and form a part of the original request and any policy issued.

Dated at ____________________ this ____________ day of ____________

Employer (full legal name) ____________________

Signature of Authorized Person ____________________ Print Name and Title ____________________

Licensed Resident Agent (signature) ____________________ P.O. Box Address (including zip code) ____________________

Print Name of Agent and License Number ____________________

UnitedHealthcare Specialty Benefits Agent/Broker Disclosure

Agent/Broker Information (Please complete all fields in each applicable section).		
Commissions payable to (mark only one): ❍ Broker/Agent ❍ Agency		
THIS SECTION REQUIRED IF COMMISSIONS WILL BE PAID TO AN AGENCY.		
AGENCY NAME (ENTER "N/A" IF AGENCY IS NOT TO BE PAID ANY COMMISSIONS):		TAX ID:
THIS SECTION **ALWAYS REQUIRED FOR AGENT/BROKER SIGNING THE GROUP APPLICATION.**		
BROKER NAME (PLEASE PRINT CLEARLY):	NAME SPECIFIC COMMISSION SCHEDULE: **DO NOT USE GENERIC REFERENCE, I.E. STANDARD SCHEDULE**	SPLIT (If Applicable)
UHC BROKER ID OR INDIVIDUAL SSN/TAX ID: **DO NOT ENTER AGENCY TAX ID.**	BROKER SIGNATURE:	DATE SIGNED:
PHONE NUMBER	EMAIL ADDRESS:	
THIS SECTION REQUIRED IF SECOND AGENT/BROKER SIGNS THE APPLICATION AND/OR IS PAID COMMISSIONS.		
BROKER #2 NAME (IF APPLICABLE):	NAME SPECIFIC COMMISSION SCHEDULE: **DO NOT USE GENERIC REFERENCE, I.E. STANDARD SCHEDULE**	SPLIT (If Applicable)
#2 UHC BROKER ID OR INDIVIDUAL SSN/TAX I.D.: **DO NOT ENTER AGENCY TAX ID.**	BROKER #2 SIGNATURE:	DATE SIGNED:
PHONE NUMBER:	EMAIL ADDRESS:	
THIS SECTION REQUIRED IF COMMISSIONS WILL BE PAID TO A GENERAL AGENT.		
GENERAL AGENT (ENTER "N/A" IF NOT APPLICABLE):	G.A. OVERRIDE:	TAX ID:

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. We may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions 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.

By signing below, the Employer acknowledges receipt of this Agent/Broker Disclosure.

Employer (Full Legal Name) **PLEASE PRINT** ____________________

Signature of Authorized Person: ____________________ Date ____________

Name & Title of Authorized Person **PLEASE PRINT** ____________________

REV. 01/2013

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in CALIFORNIA:
The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by us.

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For residents of Connecticut: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For residents of Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

For residents of Kentucky: 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.

For residents of Maine: 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.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For residents of Virginia: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

For residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.