

Employer Application



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. Complete the Coverage and Benefit Options page(s) and attach to the application (if applicable).
4. Submit the most recent billing statement listing those currently insured and current status.
5. Submit most recent wage and tax statement.
6. Include a deposit check for the first month's premium.

Dental Managed Indemnity
 Dental Options PPO
 Dental Benefits provided by:
 UnitedHealthCare Insurance Company

General Information

Requested Effective Date _____

Group Name _____

| | | | |
|--------------------------------|------------------|---------------|----------|
| Address | | Tax ID | |
| City | | State | Zip Code |
| | | County | |
| Contact Person | Telephone () | Fax () | |
| Billing Address (if different) | | Email Address | |

Multi-location group? # of Locations Address (please list locations on additional sheet)
 Yes No

| | | |
|--------------------------|--------------------|---------------|
| # Years in Business/Date | Nature of Business | Industry Code |
|--------------------------|--------------------|---------------|

Type of Organization C-Corporation Limited Liability Company Nonprofit Organization S-Corporation Independent Contractor Other _____
 List names of eligible employees/dependents currently on COBRA/Continuation _____ See attached list

| | | | | | |
|-------------------|-----------------------|-----------------------|---|-----------|--|
| Total # Employees | # Full Time Employees | # Part Time Employees | # Applying (Please include those employees in their waiting period) | # Waiving | # Hours per week to be Considered Eligible |
|-------------------|-----------------------|-----------------------|---|-----------|--|

| | | | |
|-----------------------|---------------------------|---------------|--|
| # Termed in 12 months | Wait Period for New Hires | Date of Event | Waiting Period Waived at Initial/Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------------|---------------------------|---------------|--|

| | |
|--------------------------------|---------------|
| Name of Current Dental Carrier | # Yrs Covered |
|--------------------------------|---------------|

| | | |
|--|---|---|
| Employer Contribution – Single _____% Medical Family _____% | Employer Contribution – Single _____% Dental Family _____% | Classes Excluded <input type="checkbox"/> Union/Non Union <input type="checkbox"/> Other _____ |
|--|---|---|

| | |
|-----------------------|--|
| Worker's Comp Carrier | List Owners/Partners not covered by WC |
|-----------------------|--|

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

COBRA Continuation Under federal law if your group had 20 or more employees on at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had less than 20 employees, you must provide State Continuation.

Medicare Primary Health Plan Primary Under federal law if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary.

Broker Information

| | | |
|-------------|--------|--------------------------|
| Broker Name | Agency | Agent Code/Tax ID Number |
|-------------|--------|--------------------------|

| | | |
|-----------|-------------------|------|
| Signature | Social Security # | Date |
|-----------|-------------------|------|

| | |
|----------|-------|
| Rep Name | Rep # |
|----------|-------|

The Company certifies that the information provided is complete and accurate. Company shall notify the Insurer 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, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer 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 this Policy.

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 material omissions, misrepresentations or misstatements in the information requested on this form can result in the voiding or reformation of insurance.

Any person who includes any false or misleading information on an application for health care coverage is subject to criminal and civil penalties.

Signature (Form must be signed)

Signature _____ **Date** _____ **Title** _____

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