

# Application for a Small Employer Health Benefits Policy

Please print or type all information, using ink.

Policy Number \_\_\_\_\_  
(UnitedHealthcare use only)

**Section I: Policyholder Information**       New Policy       Change in Policy      Requested Effective Date \_\_\_\_\_

Policyholder (full legal name of company)				Tax Identification Number			
Main Address: Street			City		State		Zip Code
Mailing Address: Street			City		State		Zip Code
Name of Correspondent				Telephone (     )		Facsimile (     )	
Type of Organization <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (explain) _____			Nature of Business (specify)			SIC Code	
Number of eligible employees in your company		Number of eligible employees to be insured		Class or classes to be excluded		Insurance requested for: <input type="checkbox"/> Employees only <input type="checkbox"/> Employees & Dependents	

**Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.**

Are you subject to the requirements of COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		Waiting period before employees may become insured (may not exceed 6 months) Present employees: _____      New or Rehired employees: _____					
What percentage of the premium will the employer pay?		Deposit \$ _____		Premium <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly paid <input type="checkbox"/> Automatic checking withdrawal		<b>Premium will be due as of effective date. The premium for the first month of coverage must be attached.</b>	

**Affiliates, subsidiaries or branches (Must be included for purposes of participation)**

Legal Name and Location	Number of eligible employees in this company	Number of eligible employees to be insured

**Section II: Specifications for Coverage**

Open Access Product	Plan	Office Copay/ Coinsurance	Deductible		Hospital Copay	Coinsurance		OOP Maximum/Charge		ER Copay
			In Network Ind/Family	Out of Network Ind/Family		In Network	Out of Network	In Network Ind/Family	Out of Network Ind/Family	
<input type="checkbox"/> CHOICE HMO	TM-C	\$10/100%	\$0/\$0	N/A	\$0	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	NJ-X	\$10/100%	\$0/\$0	N/A	\$100 per day	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	TM-D	\$15/100%	\$0/\$0	N/A	\$0	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	NJ-Y	\$15/100%	\$0/\$0	N/A	\$150 per day	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-A	\$20/100%	\$0/\$0	N/A	\$0	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-C	\$20/100%	\$0/\$0	N/A	\$250 per day	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-N	\$20/100%	\$500/\$1,000	N/A	Ded. & Coinsurance	90%	N/A	\$1,500/\$3,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-O	\$20/100%	\$1,000/\$2,000	N/A	Ded. & Coinsurance	90%	N/A	\$2,000/\$4,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-P	\$20/100%	\$500/\$1,000	N/A	Ded. & Coinsurance	80%	N/A	\$2,500/\$5,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-Q	\$20/100%	\$1,000/\$2,000	N/A	Ded. & Coinsurance	80%	N/A	\$2,500/\$5,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-R	\$20/100%	\$500/\$1,000	N/A	Ded. & Coinsurance	50%	N/A	\$2,500/\$5,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-B	\$30/100%	\$0/\$0	N/A	\$0	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-D	\$30/100%	\$0/\$0	N/A	\$300 per day	100%	N/A	N/A	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-S	\$30/100%	\$500/\$1,000	N/A	N/A	90%	N/A	\$1,500/\$3,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-T	\$30/100%	\$1,000/\$2,000	N/A	N/A	90%	N/A	\$2,000/\$4,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-U	\$30/100%	\$500/\$1,000	N/A	N/A	80%	N/A	\$2,500/\$5,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-V	\$30/100%	\$1,000/\$2,000	N/A	N/A	80%	N/A	\$2,500/\$5,000	N/A	\$50
<input type="checkbox"/> CHOICE HMO	LP-W	\$30/100%	\$500/\$1,000	N/A	N/A	50%	N/A	\$2,500/\$5,000	N/A	\$50

Open Access Product	Plan	Office Copay/Coinsurance	Deductible		Hospital Copay	Coinsurance		OOP Maximum/Charge		ER Copay
			In Network Ind/Family	Out of Network Ind/Family		In Network	Out of Network	In Network Ind/Family	Out of Network Ind/Family	
<input type="checkbox"/> CHOICE PLUS POS	UF-O	\$10/100%	N/A	\$1,000/\$2,000	\$0	100%	70%	N/A	\$3,000/\$6,000	\$50
<input type="checkbox"/> CHOICE PLUS POS	JX-I	\$10/100%	N/A	\$1,000/\$2,000	\$100 per day	100%	70%	N/A	\$10,000 charge	\$50
<input type="checkbox"/> CHOICE PLUS POS	UF-R	\$15/100%	N/A	\$1,000/\$2,000	\$0	100%	70%	N/A	\$3,000/\$6,000	\$50
<input type="checkbox"/> CHOICE PLUS POS	JX-M	\$15/100%	N/A	\$1,000/\$2,000	\$150 per day	100%	70%	N/A	\$10,000 charge	\$50
<input type="checkbox"/> CHOICE PLUS POS	UF-T	\$20/100%	N/A	\$1,000/\$2,000	\$0	100%	70%	N/A	\$3,000/\$6,000	\$50
<input type="checkbox"/> CHOICE PLUS POS	LP-K	\$20/100%	N/A	\$1,000/\$2,000	\$250 per day	100%	70%	N/A	\$3,000/\$6,000	\$50
<input type="checkbox"/> CHOICE PLUS POS	LP-L	\$30/100%	N/A	\$1,000/\$2,000	\$0	100%	70%	N/A	\$3,000/\$6,000	\$50
<input type="checkbox"/> CHOICE PLUS POS	LP-M	\$30/100%	N/A	\$1,000/\$2,000	\$300 per day	100%	70%	N/A	\$3,000/\$6,000	\$50
<input type="checkbox"/> OPTIONS PPO	AP-E	\$20/100%	\$1,000/\$2,000	\$1,500/\$3,000	Ded. & Coinsurance	80%	60%	\$2,500/\$5,000	\$4,500/\$9,000	\$50
<input type="checkbox"/> OPTIONS PPO	AP-B	\$20/100%	\$1,000/\$2,000	\$1,500/\$3,000	Ded. & Coinsurance	90%	70%	\$2,000/\$4,000	\$4,500/\$9,000	\$50
<input type="checkbox"/> OPTIONS PPO	AP-F	\$30/100%	\$1,000/\$2,000	\$1,500/\$3,000	Ded. & Coinsurance	80%	60%	\$2,500/\$5,000	\$4,500/\$9,000	\$50
<input type="checkbox"/> OPTIONS PPO	AP-D	\$30/100%	\$500/\$1,000	\$1,500/\$3,000	Ded. & Coinsurance	80%	60%	\$2,500/\$5,000	\$4,500/\$9,000	\$50
<input type="checkbox"/> OPTIONS PPO	AP-C	\$30/100%	\$1,000/\$2,000	\$1,500/\$3,000	Ded. & Coinsurance	90%	70%	\$2,000/\$4,000	\$4,500/\$9,000	\$50
<input type="checkbox"/> OPTIONS PPO	AP-A	\$30/100%	\$500/\$1,000	\$1,500/\$3,000	Ded. & Coinsurance	90%	70%	\$1,500/\$3,000	\$4,500/\$9,000	\$50

Product Type	Plan Code	Pharmacy Copay	Mail Order (90 Day Supply)
<input type="checkbox"/> RX Drugs	D4	\$10 / 15	\$30 / \$45
<input type="checkbox"/> RX Drugs	K2	\$7 / \$25 / \$40	\$21 / \$75/ \$120

**Section III: All questions must be answered**

1. Is there any Group Health Plan:   
 now in force and to be continued?  Yes  No   
 currently being applied for?  Yes  No   
 If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

2. Name of present or prior group carrier \_\_\_\_\_ Effective date of coverage \_\_\_\_\_ Cancellation/termination date \_\_\_\_\_

Is the coverage applied for in this application replacing other group insurance?  Yes  No   
 If "Yes" give reason \_\_\_\_\_

Plan being replaced:  A  B  C  D  E   
 HMO  HMO-POS  Dual Contract POS  Other \_\_\_\_\_

3. Has your firm been uninsured for 3 or more months prior to application?  Yes  No

4. What forms of insurance are now or were in force?  Health Benefits   
 Prescription Drugs (attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits?  Yes  No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?  Yes  No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:   
 Are any employees or dependents presently incapacitated?  Yes  No   
 Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if Items 1, 2 or 3 were answered "Yes." Refer to the question number, and give details including names, where appropriate.

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**Section IV: Agent/Producer Information**

To be supplied by UnitedHealthcare, and limited in scope to information concerning the agent/broker

Agent Name

Address: Street

City

State

Zip Code

Telephone

( )

SECOND AGENT OR SUB-AGENT (if applicable)

Agent Name

Address: Street

City

State

Zip Code

Telephone

( )

**Section V: Commission Data**

Application taken at

City

State

Agent Code &amp; Suffix, if any

If more than one agent,  
percent of productionIs agent appointed with  
UnitedHealthcare?  Yes  NoFederal Taxpayer Number  
(Social Security or other number)

SECOND AGENT OR SUB-AGENT (if applicable)

Application taken at

City

State

Agent Code &amp; Suffix, if any

If more than one agent,  
percent of productionIs agent appointed with  
UnitedHealthcare?  Yes  NoFederal Taxpayer Number  
(Social Security or other number)**Section VI: Signature**

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of UnitedHealthcare to make or modify any request or application for insurance or to bind UnitedHealthcare by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by UnitedHealthcare. Final rates will be based on final enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

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

Date at \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
Print name of Officer, Partner or Proprietor\_\_\_\_\_  
Signature of Officer, Partner or Proprietor\_\_\_\_\_  
Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Medical insurance provided by or through  
UnitedHealthcare of New Jersey, Inc.  
United HealthCare Insurance Company