Employer Application for an Association Health Plan

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. Include a deposit check in the amount of any required payment amount. Such amount will be returned in the event coverage does not become effective and will be applied against the first month's payment amount if coverage does become effective.

Association Health Plan (AHP) Name:
AHP Tax ID:
Association type: ☐ Industry ☐ Geographic
Requested Effective Date:

General Information

Group's/Company's Legal Name

Street Address				Group Tax ID
City	State	Zip Code	Names of Owners/Partners (if applicable)	Internet Access? ☐ Yes ☐ No
Contact Person:		Email Address:		# of Years in Business:
Billing Address (if different):		Telephone:		Fax:

Multi-location group/company ☐ Yes ☐ No	# of Locations	Address (es) (or list on additional sheet of paper)
Working Owner/Sole Proprietor (no common law employees) ☐ Yes ☐ No If Yes, indicate # of Working Owners _____		Organization Type: ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Other _____ Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No

Nature of Business	Industry Code	Domestic Partner Coverage? ☐ Yes ☐ No	Medical Benefit Plan Option ☐ Calendar Year ☐ Plan Year
Names of Persons currently on COBRA/Continuation and/or Short/Long Term Disability: ☐ See Attached List ☐ None			Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary

Have Workers' Comp: ☐ Yes ☐ No	Name of Workers' Compensation Carrier:	Names of Owners/Partners not covered by Workers' Compensation:

Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days)	Waiting Period waived for initial enrollees
☐ 1st of Coverage Month following Date of Hire ☐ 1st of Coverage Month following ___ ☐ months/☐ days of employment ☐ Date of Hire (no waiting period) ☐ ____ ☐ months/☐ days of employment following Date of Hire	☐ Yes ☐ No

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
# Hours per week to be eligible _____		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
For Disability products the minimum # of work hours per week to be eligible is 30 hours.		Dep Life		Dep Life		Dep Life		
		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
		LTD		LTD		LTD		

Group Name _____

General Information (continued)

Enter the Prior Calendar Year Average Total Number of Employees Eligible for Coverage: Include working owners if allowed by your association. ☐	The number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage. To calculate the annual average, add all the monthly employee totals together then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).
Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees ☐	For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

☐ Yes ☐ No	Subject to ERISA? (Most private sector plans are ERISA plans) If No, you are not eligible for coverage.
☐ Yes ☐ No	In the past 36 months, has the Group/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 Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ Yes ☐ No	Does your group sponsor a plan that covers employees of more than one employer? If you answered Yes, then indicate which of the following most closely describes your plan: ☐ Professional Employer Organization (PEO) ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Taft Hartley Union ☐ Governmental ☐ Church ☐ Employer Association
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group coverage. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that the AHP will not cover the co-employees under this group coverage.
☐ Yes ☐ No	Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?
☐ Yes ☐ No	Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required AHP payment amounts, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

☐ Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined on page 1).

☐ No, we do not offer medical coverage during a leave of absence.

Group Name _____

Consumer Driven Health Plan Options

Health Savings Account (if selected): Which bank will be used: ☐ OptumBank ☐ Other

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to the coverage under the AHP?

Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No

If yes, please identify type: ☐ UnitedHealthcare HRA (any HRA design offered through UnitedHealthcare)
☐ Other Administrator HRA

HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this AHP will require you to notify UnitedHealthcare.

Current Carrier Information

Does the group currently have any coverage with United Healthcare Services, Inc. and Affiliates or has the group had any United Healthcare Services, Inc. and Affiliates coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			
Current Vision Carrier	☐ None			

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify United Healthcare Services, Inc. and affiliates (collectively "United") 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.

I represent the information I have provided is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, in the information requested on this form can result in the adjustment of rating or voiding of insurance.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information, or conceals information for the purpose of misleading, in an application for coverage is guilty of a crime and may be subject to fines and confinement in prison.

United disclosure regarding producer compensation:

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. In certain states, we may pay "base commissions" based on factors such as product type, cost of coverage, group/company size and number of employees. These commissions, if applicable, are reflected in the cost of coverage. 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 cost of coverage 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 your association as required by applicable federal law. For specific information about the compensation payable with respect to your particular coverage, please contact your producer.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in rescission of the group's Association Health Plan coverage, termination of coverage, an increase in payment amount retroactive to the coverage date, or other consequences as permitted by law.

Signature (Form must be signed)

Group/Company Signature: _____ **Date:** _____

Title:_____

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

Group Name _____

Producer Information (if applicable)

Producer Name	Agency	Agent Code/Tax ID Number

Email Address	Social Security #	Phone Number

All Payments to:	Producer Commission Schedule (if applicable) _____ Std Scale of _____%

Street Address	City	State	Zip Code

Producer Signature	Date

Rep Name	Rep #

General Agent Information (if applicable)

General Agent	Phone #	Franchise Code

Street Address	City	State	Zip Code