For use with groups installed on the

PRIME PLATFORM

For Office Use Only: PRIME Platform

Specialty Combined Group Application

Group Dental Insurance, Vision Care Insurance, Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, and Long Term Disability provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

Requested Effective Date of Coverage: / /

GENERAL INFORMATION

Group's Full Legal Name:				
Group Name as it will Appear on Dental and Vision ID Cards (Max 30 characters):				
Street Address:		City:	State:	Zip Code:
Contact Name:	Phone Number:	Fax Number:	E-Mail:	
Billing Address (If Different):				
Billing Contact:		Billing Contact Phone:		
Tax ID Number:	Number of Years in Existence:	Is the group subject to ERISA? ☐ Yes ☐ No		
Nature of Business/Organization:	Industry Code (SIC):	List all subsidiaries to be included:		
Multi Location Group? ☐ Yes ☐ No	Number of Locations:	List Locations:		

Organization Type: ☐ Corporation ☐ Political Subdivision ☐ Other*: _____
☐ Partnership ☐ Sole Proprietor
*Other group types may be subject to regulatory approval.

Names Of Owners/Partners:

Did you employ anyone other than yourself and your spouse/partner in a Civil Union* during the preceding calendar year? ☐ Yes ☐ No

*Civil Union means a relationship that meets the requirements for a civil union pursuant to the New Jersey Civil Union Act and same sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary ☐ Other Excluded Class _____

Domestic partner coverage: ☐ Yes ☐ No

Will there be an Eligibility Waiting Period for New Hires? ☐Yes ☐No

If Yes, fill in: _____ days of employment from the date of hire; or _____ months of employment from the date of hire;

or 1st of month following _____ days of employment; or 1st of month following _____ months of employment

Waiving the initial waiting period ☐Yes ☐No

For Dental or Vision Coverage: ☐ COBRA or ☐State Continuation

If checked, provide total # of COBRA / Continuation participants in total group _____

ELIGIBILITY / PARTICIPATION

Total Number of Eligible Employees:		Minimum # of hours worked per week to be eligible for coverage	
Total Number of full-time Employees:		Minimum # of hours worked per week to be eligible for Disability coverage if different from the above*	

*For disability products the minimum # of hours per week to be eligible is 30 hours.

PLAN SELECTION AND INFORMATION

Products	Check your selection and fill in the Amount or Plan Code	% Premium contribution by Group	
		Employee	Dependents
Dental	☐ _____	_____%	_____%
Vision	☐ _____	_____%	_____%
Group Life			
• Basic Life / AD&D	☐ _____	_____%	N/A
• Supplemental Life / AD&D	☐ _____	_____%	N/A
• Basic Dependent Life / AD&D	☐ _____	N/A	_____%
• Supplemental Dependent Life / AD&D	☐ _____	N/A	_____%
Short Term Disability	☐ Core _____	_____%	N/A
	☐ Buy up _____	_____%	N/A
Long Term Disability	☐ Core _____	_____%	N/A
	☐ Buy up _____	_____%	N/A

REPLACEMENT / PRIOR COVERAGE INFORMATION

Products	Do you intend to use this policy to replace a similar plan?	Prior Carrier's Name	Prior Policy #	Termination Date
Dental	☐Yes* ☐No			
Vision	☐Yes ☐No			
Group Life	☐Yes ☐No			
Short Term Disability	☐Yes ☐No			
Long Term Disability	☐Yes ☐No			

* If Dental Coverage is being replaced, was prior dental policy in force for the past 12 consecutive months? ☐Yes ☐No

PRODUCER INFORMATION

Producer Name:			
Producer Signature:		Date:	
Street Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:	
Producer Number:	Tax ID Number:		
Commissions Payable To:		Commission split % (if applicable):	

Note: **Provide information in a separate sheet if more than one producer.**

GENERAL AGENT INFORMATION

General Agent Name:		Tax ID Number:	
Street Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:	
Commissions Payable To:		Franchise Code:	

PRODUCER COMPENSATION DISCLOSURE

UNITEDHEALTHCARE INSURANCE COMPANY 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, amount of premium, group/company size and number of employees. These commissions, if applicable, 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.

AGREEMENT

The Group 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.

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 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 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/members 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/members or their dependents, including the addition of newly eligible employees/members or dependents. I understand and agree 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/members.

GROUP SIGNATURE (form must be signed)

Group Authorized Person's Name (Print):	Title:
Group Authorized Person's Signature:	Date:

FRAUD WARNING NOTICE:

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