Employer Application – Alternate Funding

All Savers®

Have you:

- Signed all forms necessary for health plan application?
- Answered all applicable questions?
- Selected a method of payment?
- Enclosed a check for the initial payment?
- Enclosed a voided check if you selected Electronic Funds Transfer for ongoing payments?

Please Send Correspondence To:
P.O. Box 19032, Green Bay, WI 54307-9032
1-800-291-2634

Employer Data

Employer Tax ID No.			
Full Legal Business Name			
Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP
Phone No.	Fax No.	County	
Nature of Business	SIC	Date Business Started	
Administrative Contact Person	Executive Contact Person		
Contact Person email			
Third-Party Administrator **United HealthCare Services Inc.**	Legal Name of the Plan		

☐ Yes ☐ No Is your company (you) subject to COBRA? (Your company is subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full- or part-time employees on at least 50 percent of the typical business days during the previous calendar year. You must include employees residing outside the United States. Church plans and federal, state, and local government plans are excluded from COBRA.) Give the names of persons currently under COBRA, state continuation plan, or within their election period:

Employee/Dependent Name	Termination Date of Employment or Qualifying Event	Employee/Dependent Name	Termination Date of Employment or Qualifying Event

☐ Yes ☐ No Has your company ever had a group insurance application denied by an insurer? If yes, give name of insurer, date and reason:

☐ Yes ☐ No Is current group medical coverage being replaced? If yes, please attached Certificate of Creditable Coverage and give anticipated termination date:

List the name, address and phone number of your company's present medical carrier or Third-Party Administrator (TPA)

Carrier Name			
Carrier Address	City	State	ZIP
Carrier Phone No.	Effective Date	Termination Date	

☐ Yes ☐ No Has your medical plan been previously underwritten or administered by UnitedHealthcare Insurance Company or any of its affiliates in the last three years?

Indicate the Employer contribution amounts (minimum contribution 50%): What percentage of the costs will you pay for employees (EE)? _____% For dependents (spouse and children)? _____%	**Indicate the Employer default plan:** Which default plan did you choose for your business? (Including the letter and number of the plan code) _____

What class of employees do you want to exclude from this plan? (Check all that apply)
☐ None ☐ Union ☐ Non-Union ☐ Hourly ☐ Salary ☐ Non-management ☐ Management

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Employee Data

How many employees does your company currently have on the payroll? _____

Employees working a minimum of 30 hours per week (not part-time, temporary, or substitute) are Eligible Employees.

Number of Eligible Employees _____

Number of Eligible Employees waiving coverage _____

Number of enrolling Employees _____

Employee effective date

☐ Immediate after date of hire
☐ Immediate after 30 days
☐ Immediate after 60 days
☐ Immediate after 90 days
☐ First of month after date of hire
☐ First of month after 30 days
☐ First of month after 60 days

Employee termination date: ☐ End of month

☐ Yes ☐ No Does your current health insurer extend coverage for disabilities after termination date? (If yes, provide copy of policy and/or employee certificate.)

☐ Medicare Primary
☐ Plan Primary

Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.

Prior calendar year average total number of employees _____

Under Health Care Reform law, 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).

Termination of Employment When Employee Service Ends

The Employer terminates employment after an employee has not worked for the Employer for ____ work days (e.g., 3, 5, 10 work days). If labor laws such as FMLA or any other terms, conditions or contract of employment require that the Employer continue to employ an employee for a longer period of time, the Employer will give written notice to the Third-Party Administrator when the Employer terminates employment for that employee.

Effective Date

Enrollment forms may be submitted with a requested effective date. The effective date will be determined by the Third-Party Administrator in accordance with the provisions of the Summary Plan Description. Do not cancel your current coverage. Coverage is not in effect until you receive written confirmation from the Third Party Administrator.

Requested effective date:_____

Payment: Cash With Application/Applicable Fees

The group's first month's payment plus all applicable fees must be submitted by check with this form. All future payments must be paid with an employer's check or automatically withdrawn through the employer's checking account. **Checks must be made out to United HealthCare Services, Inc.**

A $25 fee will apply for each future payment made by Direct Bill (does not apply to the first month's payment submitted with the application). The billing fee covers the cost of monthly processing of each account. Nonpayment of this fee will result in termination of the Administrative Services Agreement and Excess Loss Insurance coverage. Payments made by Electronic Fund Transfer do not have a billing fee.

Total Payment Deposit: $_____ A service fee will be applied to non-sufficient funds.

Employer Agreement

The agent has explained the details of the coverage and I, the undersigned, acknowledge reading the entire application. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Applicant and United HealthCare Services, Inc. only when the Application receives written approval from United HealthCare Services, Inc.

All enrollees requesting or changing coverage must submit complete medical history. Approval of such changes is subject to United HealthCare Services, Inc. underwriting guidelines. All late enrollees will be declined or excluded for a period of time. Late enrollees are those whose enrollment form is received more than 31 days following their initial eligibility date.

I understand that the information provided on this application and on the Employee Enrollment Application Form is used to make decisions regarding eligibility and pricing. I also understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake) by the Employer, agent of the Employer, Employee or Participant covered under the Plan, could materially affect the underwriting, premium, rating or terms and conditions of the Employer's Excess Loss Coverage. In addition, such misrepresentation, concealment, omission of fact or a mistake of fact (whether or not a mutual mistake) could result in increased premium rates, attachment points and/or otherwise change the terms and conditions of the Employer's Excess Loss Insurance Policy retroactive to the effective date or as of any premium due date thereafter or termination of that Policy as of the next premium due date. I also understand that the Excess Loss Insurance Policy may be declared null and void in its inception if the Employer, any agent of the Employer, or Employee or Participant covered under the Plan has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of the Excess Loss Insurance Policy.

I further certify that Employer is an employer eligible to sponsor a group health plan under federal law known as ERISA. I also certify that the individuals covered under the Employer's group health plan are common law employees. United HealthCare Services, Inc. or its affiliates reserves the right to terminate the parties' agreement in the event that information shows that the Employer is not eligible to sponsor a group health plan.

Coverage is not in effect until the undersigned receives written approval from United HealthCare Services, Inc. Final approval or disapproval is not taken on the Application until all required information in the Application and all required information for enrolling employees and their dependents is submitted and reviewed. No person other than an officer of United HealthCare Services, Inc. has the authority to bind or alter coverage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to the Employer if coverage is declined.

United HealthCare Services, Inc. reserves the right to contact any employee at the place of business to complete the enrollment process. Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be guilty of insurance fraud, which is a crime, and may be subject to fines and confinement in prison.

Important Notice For Government Contractors: The All Savers Alternate Funding product is not available to any government contractor which is prohibited by contract, regulation or otherwise from receiving a refund or credit of any surplus or money (including the refund or credit of surplus under the All Savers Alternate Funding product) that was allocated under their government contract to pay for employee benefits. If you have any questions about whether you are subject to such a prohibition, please consult with your legal counsel, as United HealthCare Services, Inc. is not able to provide you with legal advice on such matters. By completing and signing this application you are representing to United HealthCare Services, Inc. that you are not prohibited by government contract, regulation or otherwise from receiving a refund or credit of any surplus or money under the All Savers Alternate Funding product.

Unless all pages are attached and completed, this will not be considered as a complete Application.

Dated At (City and State) _____ Dated On (Month, Day, and Year) _____

Legal Business Name _____

Signature X_____ (Must be signed by a person authorized to purchase coverage for the Employer.)

Print Name and Title _____

Producer Information

I hereby certify that all information contained in this form has been explained to the Employer and that the answers are correct to the best of my knowledge. I am not aware of anything unfavorable about the Employer or any person proposed for coverage except as noted herein. I have complied with the underwriting rules and regulations of the Third Party Administrator and have explained to the Employer the coverages, limitations and exclusions, and other details of the coverage applied for.

I have notified the Employer not to terminate present coverage until notified in writing by United HealthCare Services, Inc. of acceptance of this Application. I certify that I have delivered copies of the Notice of Information Practices for all current enrollees in the group, and I certify that I have instructed and will assist the employer to deliver copies of the Notice to all future enrollees in the group, as required by law.

Producer Name Dean Clark - Legend Services, Inc.

Address 21818 Treemont Hollow Ct

Telephone No. (281) 239-6966 Fax No. ( ) _____

Social Security/Identification No. 306605335

Producer Signature X_____ Date _____

Case Submission

Please submit the following forms for application of coverage:

- ☐ Employer Application form
- ☐ Employee Enrollment forms
- ☐ Payment Authorization form
- ☐ First month's payment
- ☐ A copy of the quoted rates
- ☐ Excess Loss Insurance Application
- ☐ A copy of current billing (if replacing coverage)
- ☐ Most recent copy of Wage and Tax Report

OFFICE USE ONLY

Group Effective Date _____ Approved By_____ Date_____

Comments_____

Administered by United HealthCare Services, Inc.

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Payment Authorization Form for All Savers Alternate Funding

A. APPLICANT INFORMATION

Employer Name _____

B. INITIAL METHOD OF PAYMENT

☐ Check Enclosed

C. ONGOING METHOD OF PAYMENT

☐ Electronic Fund Transfer (EFT) (Complete EFT Authorization below.)

☐ Direct Bill Choose One (Fees may apply.):

☐ Monthly Direct Bill ☐ Quarterly ☐ Semiannual ☐ Annual

D. STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Deposit, I agree to and/or understand all of the following on behalf of my business:

It may take up to one month to establish this process.

I authorize United HealthCare Services, Inc. to debit my business checking or savings account for the monthly payment for Administrative Services, Excess Loss Insurance, and claim funding. I will ensure sufficient funds are in my business checking or savings account to cover my monthly payment. If the necessary funds are not on deposit in the account at the beginning of the month, my Administrative Services Agreement with United HealthCare Services, Inc. and Excess Loss Insurance policy with All Savers Insurance Company may be subject to termination under the terms stated in the contracts. Also, I understand my business may be subject to additional service fees incurred by United HealthCare Services, Inc. subsequent to the termination date as a result of insufficient funds.

I will promptly notify United HealthCare Services, Inc. of any change to my business checking or savings account. If a change occurs it is my responsibility to provide United HealthCare Services, Inc. with the current information.

E. ELECTRONIC FUND TRANSFER AUTHORIZATION

Type of Account: ☐ Checking ☐ Savings

Account Holder's Name _____ Financial Institution _____

(As it appears on financial institution records.)

Routing/Transit Number (9 digits required) _____ Account Number (9 digits required) _____

I(we) hereby authorize United HealthCare Services, Inc. to initiate debit entries to the account and the financial institution named above. In submitting this payment authorization with the application, I understand that the initial payment may be adjusted based on the applicant's medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. United HealthCare Services, Inc. will not be held responsible for a contract lapse or termination due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid. United HealthCare Services, Inc. is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until United HealthCare Services, Inc. has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days advance notice to terminate or change this authorization. If the automatic bank draft or direct payment by check transaction is returned for any reason, a $25 nonrefundable service fee will be applied.

Authorized or Account Holder Signature X_____ Date _____

Employer's Email Address _____

↑ DETACH HERE ↑

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