


<h2 style="margin: 0;">Specialty Combined Group Application</h2> <p style="margin: 5px 0;">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:</p> <p style="margin: 10px 0;">UNITEDHEALTHCARE INSURANCE COMPANY 185 Asylum St. Hartford, CT 06103-3408</p>	
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature of Business/Organization:	Industry Code (SIC):	List all subsidiaries to be included:	
Multi Location Group? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Locations:	List Locations:	
Organization Type:	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership	<input type="checkbox"/> Political Subdivision <input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Other*: _____ <small>*Other group types may be subject to regulatory approval.</small>
Names Of Owners/Partners:			
Did you employ anyone other than yourself and your spouse during the preceding calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Classes Excluded: <input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Management <input type="checkbox"/> Salary <input type="checkbox"/> Other Excluded Class _____			
Domestic partner coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Will there be an Eligibility Waiting Period for New Hires? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, fill in: _____ days of employment from the date of hire; or _____ months of employment from the date of hire; or 1 st of month following _____ days of employment; or 1 st of month following _____ months of employment			
Waiving the initial waiting period <input type="checkbox"/> Yes <input type="checkbox"/> No			
For Dental or Vision Coverage: <input type="checkbox"/> COBRA or <input type="checkbox"/> 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	<input type="checkbox"/> _____	_____%	_____%
Vision	<input type="checkbox"/> _____	_____%	_____%
Group Life			
• Basic Life / AD&D	<input type="checkbox"/> _____	_____%	N/A
• Supplemental Life / AD&D	<input type="checkbox"/> _____	_____%	N/A
• Basic Dependent Life / AD&D	<input type="checkbox"/> _____	N/A	_____%
• Supplemental Dependent Life / AD&D	<input type="checkbox"/> _____	N/A	_____%
Short Term Disability	<input type="checkbox"/> Core _____	_____%	N/A
	<input type="checkbox"/> Buy up _____	_____%	N/A
Long Term Disability	<input type="checkbox"/> Core _____	_____%	N/A
	<input type="checkbox"/> 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	<input type="checkbox"/> Yes* <input type="checkbox"/> No			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Group Life	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> 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 NOTICES:

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For residents of California: UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For residents of Connecticut: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated State law.

For residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.