

Illinois Small Business Employer Application

For Groups with 2-50 Eligible Employees

Mail New Cases to:

**Euclid Managers®
234 Spring Lake Drive
Itasca, IL 60143
(630) 238-1900
Fax (630) 773-8790**

New Group Checklist 2-50 Eligible Employees

Thank you for your new group submission. The following pieces of information are required when submitting a new case to UnitedHealthcare.

Group Name _____

- A **check** in the amount of the first month's premium (approximate amount is acceptable) payable to: *UnitedHealthcare of Illinois, Inc.*
- Completed UnitedHealthcare **Illinois Small Business Employer Application**.
- Copy of the most recent **billing statement** from the current carrier.
- Copy of the most recent **Quarterly Wage & Tax Statement** (employee roster portion). Indicate status of all employees listed (full-time, part-time, terminated, etc.) **In lieu of the most recent Quarterly Wage & Tax Statement, the following is needed if you are:**
 - "C" Corporation - Articles of Incorporation, Form 1120, current wage and tax or current payroll records.
 - "S" Corporation - Articles of Incorporation, Form 1120S, K-1s on owners/partners, current wage and tax or current payroll records. (Only the shareholders of an S Corporation may collect dividends as all or a part of their wages.)
 - Partnership - Partnership agreement, Form 1065 and K-1s on the partners of the partnership, current wage and tax or current payroll records (if employees are not partners). Only the partners of a partnership can take a draw from the company and still be considered an eligible employee.
 - Sole Proprietorship - Business license (if in business less than one year and a Schedule C has not been filed yet) or Schedule C, and current payroll records for employees other than the owner. Only the owner of a sole proprietorship can take a draw from the company and still be considered an eligible employee.
 - Limited Liability Company (LLC) - LLC agreement; Either C Corporation or Partnership documentation (see above).
 - Church - Form 941 and current payroll records.
 - Farm - Schedule F; current payroll records.

Individual enrollment application forms for all eligible employees: Medical History section is required for all medical and/or life applicants, including employees in a waiting period. Please make sure all applications are signed and dated.

Send your new case submission to your UnitedHealthcare Account Executive or General Agency.

Please note: The UnitedHealthcare Medical Underwriting Department reserves the right to request different or additional documents as they deem necessary.

Small Group Employer Application



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. Complete the Coverage and Benefit Options page(s) and attach to the application (if applicable).
4. Submit the most recent billing statement listing those currently insured and current status.
5. Submit most recent wage and tax statement.
6. Include a deposit check for the first month's premium.

- UnitedHealthcare Open Access
- UnitedHealthcare Choice
- UnitedHealthcare Choice Plus
- UnitedHealthcare Select
- UnitedHealthcare Select Plus
- UnitedHealthcare Options PPO
- UnitedHealthcare Options PPO 80/80
- UnitedHealthcare Managed Indemnity
- [UnitedHealthcare Rhapsody]
- [UnitedHealthcare Overture Yes No Overture Package _____(A-S)]
- UnitedHealthcare Dental Benefits**
- Dental Managed Indemnity Yes No
- Dental Options PPO Yes No
- Dental Select DHMO Yes No
- [Vision Benefits**
- Quality Yes No
- Elite Yes No]
- Life/AD&D Benefits Yes No
- Dependent Life Yes No
- Supplemental Life Yes No
- Supplemental AD&D Yes No
- Critical Illness Rider Yes No

General Information				Requested Effective Date _____			
Group Name							
Address				Tax ID			
City			State		Zip Code		County
Contact Person		Title		Telephone ()		Fax ()	
Billing Address (if different)					Email Address		
Multi-location group? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Locations	Address (please list locations on additional sheet)					
# Years in Business		Nature of Business			Industry Code		
Type of Organization <input type="checkbox"/> C-Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Nonprofit Organization <input type="checkbox"/> S-Corporation <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other _____				List names of eligible employees/dependents currently on COBRA/Continuation _____ <input type="checkbox"/> See attached list			
Total # Employees	# Full Time Employees	# Part Time Employees	# Eligible Employees	# Applying (Please include those employees in their waiting period)		# Waiving	# Hours per week to be Considered Eligible
# Termed in 12 months		Wait Period for New Hires – First of the month following _____ days of employment		Waiting Period Waived at Initial/Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No		# of Employees outside service area	
Name of Current Medical Carrier <input type="checkbox"/> None			# Yrs Covered	Name of Current Dental Carrier			# Yrs Covered
Employer Contribution – Single ___% Medical Family ___%		Employer Contribution – Single ___% Dental Family ___%		Employer Contribution – Single ___% Life Dependents ___%		Classes Excluded <input type="checkbox"/> Union/Non Union <input type="checkbox"/> None <input type="checkbox"/> Other _____	
Worker's Comp Carrier				List Owners/Partners not covered by WC		Amount of deposit check	
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)						
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be placed voluntarily into bankruptcy?						
<input type="checkbox"/> COBRA Continuation <input type="checkbox"/> State Continuation	Under federal law if your group had 20 or more employees on at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had less than 20 employees, you must provide State Continuation.						
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Health Plan Primary	Under federal law if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary.						
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a member of a "controlled group of corporations" as that term is defined by United States Code section 414(b) (Internal Revenue Code)? If yes, please give the legal names of all other corporations within the control group and the number of employees employed by each.						

Medical Profile

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

- Yes No 1. Have any employees or dependents been diagnosed or treated during the past five years for:
 - Heart disease
 - Seizures
 - Chronic Lung Disorder
 - Drug/Alcohol Abuse
 - Multiple Sclerosis
 - Congenital Disorders
 - Liver Disorders
 - Stroke
 - Kidney Disease/Kidney Failure
 - Cancer
 - Mental/Nervous Disorder
 - Lupus
 - Growth Hormones
 - Organ Transplants
 - Diabetes
 - Back Disorders
 - AIDS/HIV+
 - Muscular Dystrophy
 - Rheumatoid Arthritis
 - Intestinal Disorders
 - Connective Tissue Disorder
- Yes No 2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births.
- Yes No 3. Have any employees or dependents been hospitalized or had any surgical operations during the past 5 years?
- Yes No 4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?
- Yes No 5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?
- Yes No 6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation, Medicare and Medicaid.

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question #	Check One		Age	Date of Treatment/ Date of Recovery	Nature of Condition	Name of Medication	\$ Amount of Claims	Prognosis Current Treatment
	Employee	Dependent						

The Company certifies that the information provided above is complete and accurate. Company shall notify the Insurer 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. Prior to receiving notification of approval, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under this Policy.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Company's employees.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependent who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the voiding or reformation of insurance.

Signature (Form must be signed)

Signature _____ Date _____ Title _____

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

UnitedHealthcare of Illinois, Inc. provides the following products:

- UnitedHealthcare Select (Premier)
- UnitedHealthcare Select Plus

United HealthCare Insurance Company of Illinois provides (for Illinois employers only):

- UnitedHealthcare Open Access

United HealthCare Insurance Company of Illinois (for Illinois employers only) and United HealthCare Insurance Company both provide:

- UnitedHealthcare Choice Plus
- UnitedHealthcare Select Plus
- UnitedHealthcare Options PPO
- UnitedHealthcare Options PPO 80/80
- UnitedHealthcare Managed Indemnity
- UnitedHealthcare Overture
- [UnitedHealthcare Rhapsody]
- UnitedHealthcare Dental Managed Indemnity
- UnitedHealthcare Dental Options PPO

Dental Benefits Providers, Inc., and affiliates provide UnitedHealthcare Dental Select DHMO

Broker Commission Data



Name of Group:	Effective Date:
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This document is to be completed as part of the Employer Application.

Please indicate below the broker **OR** agency to whom commissions should be paid. ***If more than one broker or agency are to be paid, please indicate percentage in the space provided on the right*.***

1. Broker/Agency Information

Agent Code: _____

Include both broker and agency names, **but check only one box.**

Pay commissions to: _____
Broker/Agent Name Social Security # _____
* _____%

Pay commissions to: _____
Agency Name Federal Tax ID # _____

Is broker/agency appointed with UnitedHealthcare? **Yes** **No**

Signature: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Fax Number: _____ E-Mail Address: _____

2. Broker/Agency Information

Agent Code: _____

Include both broker and agency names, **but check only one box.**

Pay commissions to: _____
Broker/Agent Name Social Security # _____
* _____%

Pay commissions to: _____
Agency Name Federal Tax ID # _____

Is broker/agency appointed with UnitedHealthcare? **Yes** **No**

Signature: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Plan Use Only
Group/Policy #:

Medical Coverage and Benefit Options Checklist – 2-50 Eligible Employees

Employer Locations

Location 1	Location 2	Location 3
Contact: _____	Contact: _____	Contact: _____
Address: _____	Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____	City, State, Zip: _____
Telephone: _____	Telephone: _____	Telephone: _____
Billing Address (if different): _____	Billing Address (if different): _____	Billing Address (if different): _____
# Eligible Employees: _____	# Eligible Employees: _____	# Eligible Employees: _____
# Enrolling Employees: _____	# Enrolling Employees: _____	# Enrolling Employees: _____

Coverage and Benefit Options

Location 1	Location 2	Location 3
Product:	Product:	Product:
<input type="checkbox"/> UnitedHealthcare Choice Plus <input type="checkbox"/> UnitedHealthcare Options PPO <input type="checkbox"/> UnitedHealthcare Choice <input type="checkbox"/> UnitedHealthcare Managed Indemnity <input type="checkbox"/> UnitedHealthcare Select Plus POS <input type="checkbox"/> UnitedHealthcare Select (Premier) HMO	<input type="checkbox"/> UnitedHealthcare Choice Plus <input type="checkbox"/> UnitedHealthcare Options PPO <input type="checkbox"/> UnitedHealthcare Choice <input type="checkbox"/> UnitedHealthcare Managed Indemnity <input type="checkbox"/> UnitedHealthcare Select Plus POS <input type="checkbox"/> UnitedHealthcare Select (Premier) HMO	<input type="checkbox"/> UnitedHealthcare Choice Plus <input type="checkbox"/> UnitedHealthcare Options PPO <input type="checkbox"/> UnitedHealthcare Choice <input type="checkbox"/> UnitedHealthcare Managed Indemnity <input type="checkbox"/> UnitedHealthcare Select Plus POS <input type="checkbox"/> UnitedHealthcare Select (Premier) HMO
Medical Plan Code: _____	Medical Plan Code: _____	Medical Plan Code: _____
Rx Plan Code: _____	Rx Plan Code: _____	Rx Plan Code: _____

Note: Complete Ancillary Coverage and Benefit Options Checklist for life, AD&D and dental products

Ancillary Coverage and Benefits Options Checklist – 2-50 Eligible Employers

<i>Eligible Employees</i>	<i>Guarantee Issue</i>	<i>Minimum Life Amount</i>	<i>Maximum Life Amount</i>
2-5	N/A	\$15,000	\$50,000
6-19	\$50,000	\$15,000	\$175,000
20-50	\$100,000	\$15,000	\$250,000

Please choose ancillary products by checking the applicable box next to product desired.

Life (Including AD&D if Applicable)

- Plan A** Flat amount for each employee \$ _____
-
- Plan B** (Choose one. Indicate each employee's amount on individual enrollment form)
- Flat amount, based on position of employee.
- | Class Code Definition | Amount |
|-----------------------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
- _____ x salary (minimum _____ maximum _____)
- (Indicate each employee's salary on individual enrollment form)
-
- Dependent Life** (Choose one) Employer contribution _____%
- | | |
|--|--|
| <input type="checkbox"/> Option 1 \$2,000/\$1,000
<i>(spouse/dependent)</i> | <input type="checkbox"/> Option 3 \$7,500/\$3,750
<i>(spouse/dependent)</i> |
| <input type="checkbox"/> Option 2 \$4,000/\$2,000
<i>(spouse/dependent)</i> | |

Dental Plan:

Did group have Class III/Major Services coverage for the previous 12 consecutive months? Y N

If yes, 12 month waiting period will be waived. Please submit copy of the prior carrier's bill and a copy of the schedule of benefits.

Dental Plan Chosen:

- PPO Plan Number: _____
- Indemnity

Complete this page only if requesting life insurance

United HealthCare Insurance Company

REQUEST TO PARTICIPATE IN
UNITEDHEALTHCARE SCS GROUP LIFE INSURANCE TRUST
ISSUED IN THE STATE OF RHODE ISLAND

REQUEST TO PARTICIPATE 2-50 EMPLOYEES

A. GENERAL INFORMATION

- 1. NAME OF ENROLLING GROUP: _____
- 2. EFFECTIVE DATE: _____

B. BENEFITS

We wish to participate in above-mentioned trust for group insurance providing the following type(s) of benefits:

- BASIC LIFE AND AD&D
- DEPENDENT LIFE INSURANCE

C. AGREEMENT

The Enrolling Group (“you” or “your”) and United HealthCare Insurance Company (“we”, “us” or “our”) agree that:

THE REQUEST TO PARTICIPATE and any supplemental applications 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 you 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 of 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 the Company. Changes are an amendment to and form a part of the original request and any policy issued.

Dated at _____ this _____ day of _____, _____
Month Year

Signature of Authorized Person: _____

Print Name: _____

Title: _____

Date Signed: _____

Signature of Enrolling Group’s Agent of Record: _____

FRAUD NOTICE: 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.

Standard Administrative Options

Invoice Frequency	Monthly
Invoice Media	Electronic bill presentment or printed invoice
Payment due date	First of the month; if 15 th of the month effective date sold, first bill will be prorated for ½ month. Next bill for full month due on the 1 st .
Grace Period	31 days
	This is the number of days during which UnitedHealthcare will wait for payment without terminating the Group Policy. Late charges may be assessed against any delinquent policy.
Delinquent Policy	A policy that is not paid by the due date is considered delinquent.
Dental ID Cards	Yes
Deductible Rollover	Yes. Previous carrier's medical/dental deductible: \$ _____ /\$ _____
Mandatory Enrollment into Products	If the employer contributes 100% toward any ancillary (life and AD&D, dependent life, or dental) premium, then the employees must elect that product's coverage. It is mandatory.
Date of Birth Calculation (age/sex rated groups only)	1 st of the insurance month following date of birth
Maximum Number of Children Billed (age/sex-rated groups only)	3
Open Enrollment Period	Month prior to renewal

Standard Eligibility Provisions

Dependent/Student Maximum Age	Unmarried child up to 19 years/Unmarried child up to 25 years
Effective Date for New Hires	1 st of the insurance month following waiting period (up to six months)
Minimum Hours Worked per Week to be Eligible	30 to 40 hours (determined by employer group)
Effective Date of Termination	Last day of the insurance month in which the term occurs
Effective Date for Return to Employment (leave, strike, layoff)	1 st of the insurance month following date of return
Date for Status Change	1 st of the insurance month following change
Events	Newborn; marriage; divorce; adoption; hardship; death; loss of other coverage
Dual Coverage (employee works for 2 employers and is covered under both policies)	Not allowed
Double Coverage (husband/wife work for same employer and cover each other)	Not allowed
Handicapped Coverage	Yes, covers above and beyond maximum age. Requires documentation from physician.
Employer Plan Termination	UnitedHealthcare may terminate group coverage for: <ul style="list-style-type: none"> • Nonpayment of premiums (The group is liable for payment of premiums for the entire term the policy is in force, including the grace period.) • Not meeting contribution requirements (31 days' advance notice) • Not meeting participation requirements (31 days' advance notice)
Voluntary Termination	Coverage may be terminated on the date specified by the policyholder, after at least 31 days' prior written notice to UnitedHealthcare. The written notice must be signed by an officer of the group/policy holder.

Please note: Exclusions and coverage limitations are detailed in the certificate of coverage. If this document conflicts in any way with the certificate of coverage, the certificate's provisions prevail.