

Group Name _____

General Information (continued)

Enter the 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).

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, please indicate appropriate category:
 Church (Additional information needed) Federal Government
 Indian Tribe – Commercial Business Non-Federal Government (State, Local or Tribal Gov.)
 Foreign Government/Foreign Embassy Non-ERISA Other _____

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 policy. 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 UnitedHealthcare will not cover the co-employees under this group policy.

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.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence?
(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

- Last Day worked (following the last day worked for the minimum hours required to be eligible)
 3 Months (following the last day worked for the minimum hours required to be eligible)
 6 Months (following the last day worked for the minimum hours required to be eligible)
 UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
 No, we do not offer medical coverage during a leave of absence

*UnitedHealthcare Special Provisions Related to Medical Eligibility

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, 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.

HRA and Supplemental Insurance Information

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 this UnitedHealthcare medical plan?

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 policy will require you to notify UnitedHealthcare.

Group Name _____

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? Yes No

Who will provide account balances to UnitedHealthcare?

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare 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	<input type="checkbox"/> None			
Current Dental Carrier	<input type="checkbox"/> None			
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			
Current Vision Carrier	<input type="checkbox"/> None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

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. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?
- Yes No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?
- Yes No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?
- Yes No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?
- Yes No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?
- Yes No 6. Is any employee or dependent currently hospitalized?
- Yes No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?
 - Cancer (any type)
 - Lung disease or respiratory problem (any type)
 - Heart disease or disorder (any type)
 - Organ, tissue or cell transplant
 - Liver disease (any type)
 - Kidney disease (any type)
 - Pancreatic disorder (any type)
 - Diabetes
 - Hepatitis
 - Morbid obesity
 - Congenital abnormality
 - Vascular disease (any type)
 - Neurological disorder (any type)
 - Immunological disorder (reportable types)
 - Alcohol or drug addiction or abuse
 - Hemophilia or Blood disorder (any type)

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

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 ARMS INSURANCE GROUP LLC		Phone # (412) 835-9100	Franchise Code 0000866	
Street Address 3000 Lento Blvd.		City Bethel Park	State PA	Zip Code 15102

GENERAL AGENT EMAIL ADDRESS: mfircak@armsins.com