For Office Use: Only: PRIME or UHOPS Platform

Specialty Combined Group Application

Group Dental and Vision Insurance

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

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:		

Organization Type:	☐ Corporation ☐ Partnership	☐ Political Subdivision ☐ Sole Proprietor	☐ Other*: _____ *Other group types may be subject to regulatory approval.
Names Of Owners/Partners:			
Did you employ anyone other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No			

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 Note: RMHP plans do not include Waiting Periods
For Dental & 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*	

PLAN SELECTION AND INFORMATION

Products	Check your selection and fill in the Amount or Plan Code	% Premium contribution by Group	
		Employee	Dependents
Dental	☐ _____	_____%	_____%
Vision	☐ _____	_____%	_____%

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 fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application.

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

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

FRAUD WARNING NOTICES:

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.