

Key Account Insured Employer Application Ohio Region



UnitedHealthcare of Ohio, Inc./
United HealthCare Insurance Company

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. Include a deposit check in the amount of the estimated first month's premium; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

Non-network and medical insurance products provided by United HealthCare Insurance Company.
Non-medical products provided by United HealthCare Insurance Company. Dental products provided by Dental Benefit Providers, Inc., and affiliates.

Northeastern Market
1375 East 9th Street, Suite 700
Cleveland, Ohio 44114
(800) 468-5001 Fax (216) 771-1732

Eastern Market
9200 Worthington Road
Westerville, Ohio 43082
(800) 328-8835 Fax (614) 410-7449

Southwest Market
9050 Centre Point Drive, Suite 400
West Chester, Ohio 45069
(800) 325-4262 Fax (513) 603-6271

Requested Effective Date _____

To be completed by UnitedHealthcare Account Executive

Product Selection (i.e. Choice, Choice Plus, etc.) _____

Medical Benefit Plan Number _____ **Prescription Benefit Plan Number** _____

Quoted Rates

Product	_____	_____	_____
Employee	_____	_____	_____
Employee+Spouse	_____	_____	_____
Employee+Child(ren)	_____	_____	_____
Family	_____	_____	_____
Dual Option Identifier	<input type="checkbox"/> Yes <input type="checkbox"/> No	Overture Product	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Overture Package	_____

Ancillary Benefits

UnitedHealthcare Dental Yes No
Dental Plan Code _____

Vision Benefits
Quality Yes No
Elite Yes No

Life/AD&D Benefits _____ Yes No
Dependent Life Yes No
Dependent Life Plan Code _____

Supplemental Life Yes No

General Information

Group Name _____

Street Address _____ Tax ID _____

City _____ State _____ Zip Code _____ County _____

Contact Person _____ Telephone () _____ Fax () _____

Billing Address (if different) _____ Email Address _____

Multi-location group? # of Locations _____ Address (please list locations on additional sheet)
 Yes No

# Years in Business	Nature of Business	Industry Code
---------------------	--------------------	---------------

Number of employees/dependents currently on COBRA/Continuation	Total # Employees	# Full Time Employees	# Part Time 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]
-----------------------	---

Name of Current Medical Carrier	# Yrs with the Current Carrier	Name of Current Dental Carrier	# Yrs with the Current Carrier
---------------------------------	--------------------------------	--------------------------------	--------------------------------

Employer Contribution – Single _____% Medical Family _____%	Employer Contribution – Single _____% Life Dependent _____%	Employer Contribution – Single _____% Dental Family _____%	Classes <input type="checkbox"/> Union/Non Union Excluded <input type="checkbox"/> Other _____
--	--	---	---

Worker's Comp Carrier	List Owners/Partners not covered by Workers Compensation
-----------------------	--

Yes 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)

Yes 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?

Broker Information

Broker Name		Agency		Agent Code/Tax ID Number	
Signature		Social Security #	Phone Number		Email Address
Rep Name		Rep #			
Commissions payable to			Broker Commission Schedule _____ Std Scale of _____ %		

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. Are any eligible employees or dependents receiving disability benefits of any type including Short Term Disability, Long Term Disability, Social Security Disability Income, Workers Compensation, Medicare, Medicaid or on extended leave due to injury, disability or illness?
- Yes No 2. Are any employees or dependents contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and/or surgery?
- Yes No 3. Have any eligible employees or dependents had large claims in excess of \$10,000, or do you anticipate any large claims?

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 Number	Check One		Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	\$ 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 represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents 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 adjustment of rating or voiding of insurance.

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.

Submission of any application or filing a claim containing a false or deceptive statement, with intent to defraud or facilitate a fraud against an insurer, constitutes insurance fraud.

Upon receipt by UnitedHealthcare of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

Company agrees to contribute a minimum of 50% of the employee premium.

Signature (Form must be signed)

Client Signature _____ Date _____ Title _____

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