



# 2-99 Group Employer Application

Medical, Life, and Dental Coverage underwritten by UNICARE Life & Health Insurance Company

**FOR UNICARE USE ONLY**

Group No.	Underwriter No.	Effective Date

## 1. EMPLOYER INFORMATION – The employer certifies the following information.

Company Name			
Street Address (P.O. Box not acceptable)		City	State ZIP Code
Billing Address		City	State ZIP Code
Employer is <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other-Explain:			
Company Contact Person		Phone No. (    )	FAX No. (    )
Date Business Was Established (Mo/Yr)	Type of Business (Be specific)	E-Mail Address	SIC Code
Has the company been insured by UNICARE in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, date prior UNICARE coverage terminated: _____			
Has the employer filed for bankruptcy in the past seven years? <input type="checkbox"/> Yes <input type="checkbox"/> No			

## 2. MEDICAL COVERAGE SELECTION – MemberFlex<sup>SM</sup>

All plans OR  
 Designate specific plan options (Check as many as apply)

<b>PremierFlex Options</b> <input type="checkbox"/> Premier Flex 500 <input type="checkbox"/> Premier Flex 1000 <input type="checkbox"/> Premier Flex 2000 <input type="checkbox"/> Premier Flex 2500 <input type="checkbox"/> Premier Flex Saver 1000	<b>FlexAdvantage Options</b> <input type="checkbox"/> Flex Advantage 1000 <input type="checkbox"/> Flex Advantage 2000 <input type="checkbox"/> Flex Advantage 2500 <input type="checkbox"/> Flex Advantage Saver 2000 <input type="checkbox"/> Optional Maternity Rider for groups of 2-14 employees	<b>HSA Compatible Options</b> <input type="checkbox"/> UNICARE HSA-Compatible-A <input type="checkbox"/> UNICARE HSA-Compatible-B <input type="checkbox"/> UNICARE HSA-Compatible-C <input type="checkbox"/> Optional Maternity Rider for groups of 2-14 employees
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## 3. DENTAL COVERAGE SELECTION – MemberFlex<sup>SM</sup>

All plans OR  
 Designate specific plan options (Check as many as apply)

<b>High Options</b> <input type="checkbox"/> High Option FFS <input type="checkbox"/> High Option PPO <input type="checkbox"/> GoldPremium	<b>Medium Options</b> <input type="checkbox"/> Standard FFS <input type="checkbox"/> Standard PPO <input type="checkbox"/> GoldPlus <input type="checkbox"/> GoldStandard	<b>Low Options</b> <input type="checkbox"/> Basic FFS <input type="checkbox"/> Basic PPO <input type="checkbox"/> SilverStandard	<b>Voluntary Options</b> <input type="checkbox"/> UNICARE VB <input type="checkbox"/> UNICARE VS
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## 4. LIFE BENEFIT SELECTION – UNICARE Life and AD&D Benefit Schedule.

**Option A** – \$15,000 Flat Amount for all employees

**Option B** – Any Flat Amount higher than \$15,000, maximum \$250,000 \$\_\_\_\_\_ (Must be in increments of \$5,000)

**Option C** – Graded benefits by Job Title – **Class I:** Officers, managers, supervisors, \$30,000 – **Class II:** All other employees, \$15,000

**Option D** – Graded benefits by Job Title – **Class I:** Officers, managers, supervisors, \$50,000 – **Class II:** All other employees, \$25,000

**Option E** – Graded benefits by Job Title – **Class I:** Officers, managers, supervisors, \$100,000 – **Class II:** All other employees, \$50,000

**Dependent Life Option:**     Yes     No

## 5. RATING

**Employers with 25 or more enrolling employees – choose one rating methodology**

**Individual Rating** – each enrolling employee’s rate depends on the employee’s age, area, and family status.

**Composite Rating** – rating factors for all enrolling employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

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Date Approved	Effective Date	Date Rejected	Product Code	Group Type	Underwriting Points

**6. EMPLOYER CONTRIBUTION SELECTION**

<p><b>6A. MEDICAL CONTRIBUTION SELECTION</b></p> <p>Check one:</p> <p><input type="checkbox"/> Defined Contribution 100*</p> <p><input type="checkbox"/> Defined Contribution 80**</p> <p><input type="checkbox"/> Defined Contribution Select*** \$ _____</p> <p><input type="checkbox"/> Traditional Contribution**** _____%</p> <p><i>*Employer contributes \$100 per employee per month.</i></p> <p><i>** Employer contributes \$80 per employee per month.</i></p> <p><i>*** Employer selects contribution amount over \$100 per employee per month in \$5 increments.</i></p> <p><i>**** Employer selects contribution amount of 50% or more per employee per month.</i></p>	<p><b>6B. DENTAL CONTRIBUTION SELECTION</b></p> <p>Check one:</p> <p><input type="checkbox"/> Defined Contribution 15*</p> <p><input type="checkbox"/> Defined Contribution Select** \$ _____</p> <p><input type="checkbox"/> Traditional Contribution*** _____%</p> <p><input type="checkbox"/> Voluntary Contribution (VB and VS Plans only)**** _____%</p> <p><i>*Employer contributes \$15 per employee per month.</i></p> <p><i>** Employer selects contribution amount over \$15 per employee per month in \$5 increments.</i></p> <p><i>*** Employer selects contribution amount of 50% or more per employee per month.</i></p> <p><i>**** Employer selects contribution amount of 49% or less per employee per month.</i></p>	<p><b>6C. LIFE CONTRIBUTION SELECTION</b></p> <p><input type="checkbox"/> Employee Life Premium _____%</p> <p><input type="checkbox"/> Dependent Life Premium _____%</p>
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**6D. SECTION 125 PREMIUM ONLY PLAN (P.O.P.) OPTION**

Check if you would like to enroll in P.O.P.  
 (You must fully read the P.O.P. application booklet, complete the application form, and submit the completed form and separate enrollment check along with this Employer Application.)

**7. EMPLOYEE ELIGIBILITY**

Total number of employees (including owners): \_\_\_\_\_ Number of **ineligible** employees: \_\_\_\_\_

Number of active, full-time (minimum 30 hours per week) employees: \_\_\_\_\_ Number of **eligible** employees **declining** coverage: \_\_\_\_\_

Total number of eligible **enrolling** employees including COBRA/FMLA applicants: \_\_\_\_\_

Are all eligible employees subject to withholding as on a W-2 form?  Yes  No – Please explain: \_\_\_\_\_

**Eligibility date is on the FIRST DAY of the month following Date of Approval.**

Waiting period for future employees:  1 month  2 months  3 months

**The following to be completed by groups of 20 or more total employees and/or employer providing continuation of coverage in accordance with Title X of COBRA:** Is your group subject to COBRA?  Yes  No *If yes, please complete the COBRA/FMLA questionnaire.*

**The following question is to be completed by groups of 50 or more total employees and/or employer providing coverage in accordance with the Family and Medical Leave Act of 1993:**

Is your group subject to FMLA legislation?  Yes  No *If yes, please complete the COBRA/FMLA questionnaire.*

**8. CURRENT CARRIER – Is this plan intended to replace any existing group coverage?**

**HEALTH:**  Yes  No If yes, name of group carrier: \_\_\_\_\_ Proposed termination date: \_\_\_\_\_

**DENTAL:**  Yes  No If yes, name of group carrier: \_\_\_\_\_

**LIFE:**  Yes  No If yes, name of group carrier: \_\_\_\_\_ Anniversary date: \_\_\_\_\_

**9. EFFECTIVE DATE – Actual effective date will be assigned by UNICARE underwriting department if policy is issued.**

Requested effective date: \_\_\_\_\_

**10. LEAVE OF ABSENCE**

A. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence:  
 None  1 month  2 months  3 months  4 months

B. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence (**maximum six months**):  
 None  1 month  2 months  3 months  4 months  5 months  6 months

**11. MEDICAL INFORMATION**

To your knowledge:

1. Is any person to be covered unable to work due to injury or illness? .....  Yes  No

2. Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex?  Yes  No

If yes to either question, provide names, dates, and degree of recovery: \_\_\_\_\_

**12. WORKERS' COMPENSATION**

**Name of current Workers' Compensation carrier:** \_\_\_\_\_ Renewal date: \_\_\_\_\_

Please list the name and job title of any person to be included as a subscriber under the UNICARE coverage who is not an employee, for the purpose of Workers' Compensation law or similar legislation.

<b>Name:</b>	<b>Title:</b>	Exempt according to above requirements?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**13. SIGNATURE AND CONDITIONAL RECEIPT**

**Check the box that applies:**

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply to obtain the coverage indicated.

We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA, and therefore not subject to ERISA, apply to obtain the coverage indicated.

We represent that all information on this Application is true and complete, and that UNICARE may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, UNICARE reserves the right to reject the Application and notify us in writing. We understand and agree that coverage will be effective only if we have paid our first month's premium and have met eligibility criteria. We understand that we will be informed of acceptance and effective date in writing if this Application is issued, that we should keep prior coverage in force until so notified and that no agent or broker has the right to accept Application or bind coverage. This Application becomes a part of our contract with UNICARE. **We verify that these answers are true and that coverage may be rescinded or re-evaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms.**

Dated at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

By X \_\_\_\_\_ Title \_\_\_\_\_

*(Signature of Company Officer / Owner)*

**14. CONDITIONAL RECEIPT – Agent, please photocopy and give to your client.**

This will acknowledge receipt of \$ \_\_\_\_\_ from \_\_\_\_\_

as a deposit against the insurance premiums that would become payable if UNICARE Life & Health accepts this Application for group coverage. This check will be held in trust by UNICARE pending acceptance or rejection of the Application. I have fully explained to the employer that in no event will benefits be payable for any loss incurred before the effective date assigned by UNICARE Life & Health and that the company should retain any other coverage until then.

**15. AGENT'S CERTIFICATION**

1. I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.

2. I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from UNICARE the coverage being applied for by this application is issued.

1. Name of Writing Agent <i>(Print or Type)</i>	%	Agent Tax I.D. No. <i>(Check one)</i>	<input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
Agent Address		Phone No. (       )	FAX No. (       )
City / State / ZIP			
Signature of Agent <b>X</b>			Date
2. Name of <input type="checkbox"/> Sub-Agent <input type="checkbox"/> Second Writing Agent <i>(Print or Type)</i>	%	Agent Tax I.D. No. <i>(Check one)</i>	<input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
Agent Address		Phone No. (       )	FAX No. (       )
City / State / ZIP			
Signature of Second Agent <b>X</b>			Date
3. Name of General Agent		Agent Tax I.D. No.	

**Send Administration Kit to:**     Agent     Group