UNITEDhealthcare℠

SMALL GROUP APPLICATION (RI)

Boston Sales Office
1 Research Drive
Westborough, MA 01581
(800) 410-3385

Warwick Sales Office
475 Kilvert Street
Warwick, RI 02886-1392
(800) 447-1245

United HealthCare of New England, Inc.
United HealthCare Insurance Company
Non-medical products provided by Metropolitan Insurance Company

FOR PLAN USE ONLY - Small Group Identifier

Please circle the appropriate answer to the following questions. The "group" is defined as the entity who will be paying the monthly bill.
Y = Yes, N = No, NA = Not Applicable

Y / N	This group has fewer than 50 **eligible** employees.
Y / N / NA	This group is defined as a "small group" according to your state regulations.
Y / N	The employees of this group will complete medical questions **at initial** enrollment.

Actual Group Effective Date: ____________ ACH ____________

APPLICATION INSTRUCTIONS

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 application.
4. Submit the most recent premium statement listing those currently insured and **last quarterly wage and tax statement**.
5. Include a deposit check for the first month's premium.

GROUP INFORMATION

1. Company Name — ❑ Corporation ❑ Partnership ❑ Sole Proprietorship

2. Federal Identification Number | 3. Contact Name | 4. Title

5. Street Address | 6. City

7. County | 8. State | 9. Zip Code | 10. Phone Number | 11. Fax Number

12. Billing Address | 13. City | 14. State | 15. Zip Code

16. Worker's Compensation Carrier

17. List any employee classes excluded from coverage
❑ Part Time ❑ Seasonal
❑ Temporary ❑ Other ____________

18. Application for (check all that apply and attach the completed benefit options checklist)
❑ Medical ❑ Dental ❑ Life ❑ Dependent Life ❑ Major Medical (Out-of-Area) ❑ Short Term Disability

19. # of Yrs Company in Business | 20. Nature of Business | 21. Standard Industry Code

22.	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 11 or 7)	❑	❑
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?	❑	❑

23. Total Number of Employees (including those in waiting period) ____ Full Time (30 hrs/wk) ____ Part Time ____ | 24. Total # of eligible employees | 25. Total # of employees applying

26. # of Employees Terminated in last 12 months | 27. Requested Effective Date

28. List/Employees/Dependents on Continuation of Coverage/COBRA

29. Effective Date for New Hires: First of the month following the completion of ____ day waiting period. | 30. Previous Carriers in past 5 years

31. Minimum number of hours worked per week to be eligible (Minimum of________ 30 hrs/wk)

32. Employer Contribution

MEDICAL	______ % Single	______% Family
DENTAL	______ % Single	______% Family
LIFE	______ % Single	______% Family
SHORT TERM DISABILITY		______% Single

HEALTH INFORMATION

Please answer the following 5 questions. Explain any "YES" answers below.

To the best of your knowledge:	YES	NO
1. Has any employee/dependent been treated for a serious illness (physical or mental), had more than $5,000 of medical expenses, been hospitalized or had surgery in the past twelve months?	❑	❑
2. Is any employee/dependent apt to have a continuing claim from any existing mental or physical disorder, including pregnancy?	❑	❑
3. Has any employee/dependent been advised to have surgery in the last six months or anticipate hospitalization for any other reason?	❑	❑
4. Are there any employees/dependents who are incapacitated or confined in a hospital or treatment facility?	❑	❑
5. Are there any employees/dependents who are not actively performing their duties full time due to a disabling illness or injury?	❑	❑

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IMPORTANT - PLEASE READ CAREFULLY

The Company certifies that the information provided above is complete and accurate. Company shall notify 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. Insurer shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this Policy.

During and after termination of the Policy, Company grants Insurer permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in Insurer's possession. The parties shall maintain confidentiality of any information relating to Covered Persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without prior written consent of that party.

It is understood and agreed that: insurance will be effective only on the date specified by Insurer after the application has been approved by the Insurer and after the first full premium has been paid. The Company's cancelled check is a receipt for the deposit. The deposit will be applied to the first premium due if the application for group coverage is approved. The deposit is not refundable after the group coverage has been approved and issued.

Employer Signature X ______________________________ Date ____________________

Title ______________________________ Amount of Deposit $ ____________________

BROKER INFORMATION

Broker Name	Broker #
Agency Name	Phone No. ( ) Fax No. ( )

Address	City	State	Zip
Commission Payable To	Tax ID/SSN		

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Sales Rep Name	
Broker Commission Schedule _______ Std. Scale _______ % Flat	Sales Rep #

Broker Signature X ______________________________ Date ____________________