California Small Business Group Acceptance/Change Form

UnitedHealthcare®

Effective April 1, 2015

Please indicate reason for change: **New Business:** ☐ Acceptance of new coverage **Renewals:** ☐ Acceptance of renewal with new renewal rates: **Group #**_____ ☐ Change existing coverage: **Group #**_____	Source Code Tracking #

Important: Please Print or Type All Sections in Black Ink

Legal Name of Group/DBA	Telephone ( )		Fax ( )	
Address	City	County	State	ZIP

Employer Contribution (Medical Only): Employee Premium =_____ Dependent Premium=_____	Total Number Employed:_____

Total Permanent Full-Time Employees: *(working 30 or more hours per week)*	Total Permanent Part-Time Employees: *(working 20–29 hours per week)*	Do you wish to offer coverage to **ALL** employees working 20–29 hours per week? ☐ Yes Effective Date _____ ☐ No

Decide on the package your group is enrolling in, then select the specific plans you wish to offer to employees. If enrolling in a stand-alone plan, select only one plan.

Is a staff model HMO plan[1] being offered alongside UnitedHealthcare plans? ☐ Yes ☐ No

UnitedHealthcare Plan	Plan Description	Plan Code	Choice Simplified[2] ☐ All Plans	Multi-Choice State ☐ All Plans
Select Plus	15/10%	GN-3	☐	
Select Plus	15/250/10%	GO-V	☐	
Select Plus	15/500/10%	GO-W	☐	
Select Plus	15/1000/10%	GO-X	☐	
Select Plus	25/1800/20%	GO-Y	☐	
Select Plus	35/1800/30%	7V-M	☐	
Select Plus	4500/20%	GP-5	☐	
Select Plus HSA	2000/20%	GN-5	☐	
Select Plus HSA	3500/20%	GN-6	☐	
Core	15/10%	AB-4Y	☐	
Core	15/250/10%	AB-44	☐	
Core	15/500/10%	AB-45	☐	
Core	15/1000/10%	AB-46	☐	
Core	25/1800/20%	AB-47	☐	
Core	35/1800/30%	AB-5A	☐	
Core	4500/20%	AB-48	☐	
Core HSA	2000/20%	AB-41	☐	
Core HSA	3500/20%	AB-42	☐	
Signature[3]	20-40/250d	6X-9	☐	
Signature	30-50/1000d	6Y-A	☐	
Signature	30-50/900d/1000ded	6Y-B	☐	
Signature	30-50/25%/1750ded	3T-N	☐	
Signature	50-75/30%/4500ded	3T-P	☐	
Advantage[3]	20-40/250d	6Y-C	☐	
Advantage	30-50/1000d	6Y-D	☐	
Advantage	30-50/900d/1000ded	6Y-E	☐	
Advantage	30-50/25%/1750ded	3T-T	☐	
Advantage	50-75/30%/4500ded	3T-V	☐	
Focus[3]	20-40/250d	AB-YI	☐	
Focus	30-50/1000d	AB-YJ	☐	
Focus	30-50/900d/1000ded	AB-YK	☐	
Focus	30-50/25%/1750ded	AB-YL	☐	
Focus	50-75/30%/4500ded	AB-YM	☐	
Alliance[3]	20-40/250d	6Y-F	☐	
Alliance	30-50/1000d	6Y-G	☐	
Alliance	30-50/900d/1000ded	6Y-H	☐	
Alliance	30-50/25%/1750ded	3T-Z	☐	
Alliance	50-75/30%/4500ded	3T-2	☐	
Alliance HSA	20%/2000ded	3T-4	☐	
Alliance HSA	20%/3500ded	3T-5	☐	

Group Name _____

UnitedHealthcare Plan	Plan Description	Plan Code	Choice Simplified[2] ■ All Plans	Multi-Choice State ■ All Plans
Non-Differential PPO	2000/20%	GN-2		☐
Select	20/10%	77-C		☐
Select	30/20%	77-D		☐
Select	45/1500/20%	77-E		☐
Select HSA	4500/40%	77-F		☐
Alliance	20-40/250d	AB-GV		☐
Alliance	30-50/600d	AB-GW		☐
Alliance HSA	20%/1500ded	AB-GX		☐
Alliance HSA	40%/4500ded	77-B		☐

HSA/HRA and Supplemental Coverage

HSA/HRA

HSA (if selected) – which bank will be used: ☐ Optum Bank℠ ☐ Other

Do you currently offer or intend to offer a 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.

Supplemental Coverage		Other Coverage (Required)
Group Term Life ☐ Add* ☐ Cancel ☐ Renew ☐ Change* *Separate application required.	**Infertility - Diagnosis and Treatment (HMO only)** ☐ Add ☐ Cancel ☐ Renew	**Domestic Partners Coverage** All UnitedHealthcare plans include Domestic Partner coverage as required by state law.

The undersigned is authorized by the above Small Business Group to apply for or change group coverage offered by UnitedHealthcare Insurance Company at the attached premium rates guaranteed for 12 months effective _____ and is authorized to enter into a Medical and Hospital Group Master Policy.
Further, the undersigned agrees to make full monthly premium payments to UnitedHealthcare for the benefits received in accordance with the terms of the contract.

Authorized Signature	Date
Print Name	Title

For renewals only, please fax to **Account Management Team Fax # 1-877-296-9853.**

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

UNDERWRITING APPROVAL D.P. Only

INTERNAL USE ONLY: G.C. #

UnitedHealthcare®

Important Plan Coverage Information: All UnitedHealthcare plans are underwritten by UnitedHealthcare Insurance Company. When adding or revising plans at renewal, underwriting approval may be required. All plan change requests must be submitted to UnitedHealthcare prior to the renewal date.

[1] Groups with 5 or more enrolling employees may offer one staff model HMO plan from another carrier alongside UnitedHealthcare plans.
[2] Formal product name: UnitedHealthcare Multi-Choice®
[3] Formal HMO product names:
Signature = UnitedHealthcare SignatureValue®
Advantage = UnitedHealthcare SignatureValue Advantage
Alliance = UnitedHealthcare SignatureValue Alliance
Focus = UnitedHealthcare SignatureValue Focus

2192-111408UHCCA-HMOINS-LD
UHCCA410598-029

400-3658 3/15