

# All Savers® Alternate Funding – Employer Application

## Have you:

- Signed all forms necessary for health plan application?
- Answered all applicable questions?
- Selected a method of payment?
- Enclosed a check for the initial payment?
- Enclosed a voided check if you selected Electronic Funds Transfer?

Please send correspondence to:  
 P.O. Box 19032  
 Green Bay, WI 54307-9032  
 1-800-291-2634

## Employer Data

Employer Tax ID No.			
Full Legal Business Name			
Street Address		City	State
Mailing Address (if different)		City	State
Phone No.	Fax No.	County	
Nature of Business	SIC	Date Business Started	
Administrative Contact Person		Executive Contact Person	
Contact Person email			
Third-Party Administrator <b>United HealthCare Services Inc.</b>	Legal Name of the Plan		
<input type="checkbox"/> Yes <input type="checkbox"/> No   Is your company (you) subject to COBRA? (Your company is subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full- or part-time employees on at least 50 percent of the typical business days during the previous calendar year. You must include employees residing outside the United States. Church plans and federal, state and local government plans are excluded from COBRA.) Give the names of persons currently under COBRA, state continuation plan or within their election period:			
Employee/Dependent Name	Termination Date of Employment or Qualifying Event	Employee/Dependent Name	Termination Date of Employment or Qualifying Event
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No   Has your company ever had a group insurance application denied by an insurer? If yes, give name of insurer, date and reason:			
<input type="checkbox"/> Yes <input type="checkbox"/> No   Is current group medical coverage being replaced?			

## List the name, address and phone number of your company's present medical carrier or Third-Party Administrator (TPA)

Carrier Name			
Carrier Address		City	State
Carrier Phone No.		Effective Date	Termination Date
<input type="checkbox"/> Yes <input type="checkbox"/> No   Has your medical plan been previously underwritten or administered by UnitedHealthcare Insurance Company or any of its affiliates in the last three years?			
<b>Indicate the Employer contribution amounts</b> (minimum contribution 50%): What percentage of the costs will you pay for employees (EE)? _____% For dependents (spouse and children)? _____%		<b>Indicate the Employer default plan:</b> Which default plan did you choose for your business? (Include the letter and number of the plan code) _____ <b>Additional Plans Elected:</b> _____ (If applicable)	
What class of employees do you want to exclude from this plan? (Check all that apply.) <input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Non-management <input type="checkbox"/> Management		<b>Medical Benefit Plan Option</b> (where available) <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year	

## Employer/Employee Data

How many employees does your company currently have on the payroll? _____
Employees working a minimum of 30 hours per week (not part-time, temporary or substitute) are Eligible Employees.
Number of Eligible Employees _____
Number of Eligible Employees waiving coverage _____





## Employer Agreement

The agent has explained the details of the coverage and I, the undersigned, acknowledge reading the entire application. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Applicant and United HealthCare Services, Inc. only when the Application receives written approval from United HealthCare Services, Inc.

All enrollees requesting or changing coverage must submit complete medical history. Approval of such changes is subject to United HealthCare Services, Inc. underwriting guidelines. All late enrollees will be declined or excluded for a period of time. Late enrollees are those whose enrollment form is received more than 31 days following their initial eligibility date.

### Important Information

UnitedHealthcare reserves the right to review the applicant's payroll/wage and tax records at any time to confirm eligibility. UnitedHealthcare may request the applicant's most recent wage and tax payroll records. The applicant agrees to furnish UnitedHealthcare with all information and documentation which may be reasonably required with regard to eligibility for coverage.

I understand that the information provided on this application and on the Employee Enrollment Application Form is used to make decisions regarding eligibility and pricing. I also understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake) by the Employer, agent of the Employer, Employee or Participant covered under the Plan, could materially affect the underwriting, premium, rating or terms and conditions of the Employer's Excess Loss Coverage. In addition, such misrepresentation, concealment, omission of fact or a mistake of fact (whether or not a mutual mistake) could result in increased premium rates, attachment points and/or otherwise change the terms and conditions of the Employer's Excess Loss Insurance Policy retroactive to the effective date or as of any premium due date thereafter or termination of that Policy as of the next premium due date. I also understand that the Excess Loss Insurance Policy may be declared null and void in its inception if the Employer, any agent of the Employer, or Employee or Participant covered under the Plan has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of the Excess Loss Insurance Policy.

I further certify that Employer is an employer eligible to sponsor a group health plan under federal law known as ERISA. I also certify that the individuals covered under the Employer's group health plan are common law employees. United HealthCare Services, Inc. or its affiliates reserves the right to terminate the parties' agreement in the event that information shows that the Employer is not eligible to sponsor a group health plan.

**Coverage is not in effect until the undersigned receives written approval from United HealthCare Services, Inc.** Final approval or disapproval is not taken on the Application until all required information in the Application and all required information for enrolling employees and their dependents is submitted and reviewed. No person other than an officer of United HealthCare Services, Inc. has the authority to bind or alter coverage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to the Employer if coverage is declined.

United HealthCare Services, Inc. reserves the right to contact any employee at the place of business to complete the enrollment process. Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be guilty of insurance fraud, which is a crime, and may be subject to fines and confinement in prison.

**Important Notice for Government Contractors:** The All Savers Alternate Funding product is not available to any government contractor which is prohibited by contract, regulation or otherwise from receiving a refund or credit of any surplus or money (including the refund or credit of surplus under the All Savers Alternate Funding product) that was allocated under their government contract to pay for employee benefits. If you have any questions about whether you are subject to such a prohibition, please consult with your legal counsel, as United HealthCare Services, Inc. is not able to provide you with legal advice on such matters. By completing and signing this application, you are representing to United HealthCare Services, Inc. that you are not prohibited by government contract, regulation or otherwise from receiving a refund or credit of any surplus or money under the All Savers Alternate Funding product.

Unless all pages are attached and completed, this will not be considered as a complete Application.

Dated at (City and State) \_\_\_\_\_ Dated on (Month, Day and Year) \_\_\_\_\_

Legal Business Name \_\_\_\_\_

Signature X \_\_\_\_\_ (Must be signed by a person authorized to purchase coverage for the Employer.)

Print Name and Title \_\_\_\_\_

## Producer Information

I hereby certify that all information contained in this form has been explained to the Employer and that the answers are correct to the best of my knowledge. I am not aware of anything unfavorable about the Employer or any person proposed for coverage except as noted herein. I have complied with the underwriting rules and regulations of the Third-Party Administrator and have explained to the Employer the coverages, limitations and exclusions, and other details of the coverage applied for.

I have notified the Employer not to terminate present coverage until notified in writing by United HealthCare Services, Inc. of acceptance of this Application. I certify that I have delivered copies of the Notice of Information Practices for all current enrollees in the group, and I certify that I have instructed and will assist the employer to deliver copies of the Notice to all future enrollees in the group, as required by law.

Producer Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_

Social Security/Identification No. \_\_\_\_\_

Producer Signature X \_\_\_\_\_ Date \_\_\_\_\_

## Case Submission

Please submit the following forms for application of coverage:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Employer Application form  | <input type="checkbox"/> First month's payment      | <input type="checkbox"/> Excess Loss Insurance Application       |
| <input type="checkbox"/> Employee Enrollment forms  | <input type="checkbox"/> A copy of the quoted rates | <input type="checkbox"/> Most recent copy of Wage and Tax Report |
| <input type="checkbox"/> Payment Authorization form |   |  |

### OFFICE USE ONLY

Group Effective Date \_\_\_\_\_ Approved By \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

# All Savers® Alternate Funding Payment Authorization Form

## A. APPLICANT INFORMATION

Employer Name \_\_\_\_\_

## B. INITIAL METHOD OF PAYMENT

- Check Enclosed  
 Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)

## C. ONGOING METHOD OF PAYMENT

- Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)  
 Direct Bill – Monthly (Fees may apply)

## D. STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Deposit, I agree to and/or understand all of the following on behalf of my business:

It may take up to one month to establish this process.

I authorize United HealthCare Services, Inc. to debit my business checking or savings account for the monthly payment for Administrative Services, Excess Loss Insurance, and claim funding. I will ensure sufficient funds are in my business checking or savings account to cover my monthly payment. If the necessary funds are not on deposit in the account at the beginning of the month, my Administrative Services Agreement with United HealthCare Services, Inc. and Excess Loss Insurance policy with All Savers Insurance Company may be subject to termination under the terms stated in the contracts. Also, I understand my business may be subject to additional service fees incurred by United HealthCare Services, Inc. subsequent to the termination date as a result of insufficient funds.

I will promptly notify United HealthCare Services, Inc. of any change to my business checking or savings account. If a change occurs, it is my responsibility to provide United HealthCare Services, Inc. with the current information.

## E. ELECTRONIC FUNDS TRANSFER AUTHORIZATION

 Type of Account:  Checking  Savings

Account Holder's Name \_\_\_\_\_ Financial Institution \_\_\_\_\_  
(As it appears on financial institution records.)

Routing/Transit Number (9 digits required) \_\_\_\_\_ Account Number \_\_\_\_\_

I (we) hereby authorize United HealthCare Services, Inc. to initiate debit entries to the account and the financial institution named above. In submitting this payment authorization with the application, I understand that the initial payment may be adjusted based on the applicant's medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. United HealthCare Services, Inc. will not be held responsible for a contract lapse or termination due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid. United HealthCare Services, Inc. is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until United HealthCare Services, Inc. has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days' advance notice to terminate or change this authorization. If the automatic bank draft or direct payment by check transaction is returned for any reason, a \$25 nonrefundable service fee will be applied.

Authorized or Account Holder Signature X \_\_\_\_\_ Date \_\_\_\_\_

Employer's Email Address \_\_\_\_\_