2-50 Small 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
BILLING ADDRESS	CITY	STATE	ZIP

EMPLOYER IS ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ 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? .... ☐ Yes ☐ No If yes, date prior UNICARE coverage terminated: ________________

Has the employer filed for bankruptcy in the past seven years? .... ☐ Yes ☐ No

2. MEDICAL COVERAGE SELECTION – MemberFlex

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

High Option
☐ Performance Plus No Deductible

Medium Options
☐ Performance 500 ☐ Performance 750

Low Options
☐ Performance 1000 ☐ UNICARE Saver 1000
☐ Performance 2000

3. IN VITRO FERTILIZATION RIDER – *Must check one.*

Check one: ☐ Add rider ☐ Decline rider

4. DENTAL COVERAGE SELECTION – MemberFlex

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

High Option
☐ High Option FFS

Medium Option
☐ Standard FFS

Low Option
☐ Basic FFS

5. 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

6. EMPLOYER CONTRIBUTION

6A. EMPLOYER MEDICAL CONTRIBUTION OPTION

Check one:
☐ Defined Contribution 100*
☐ Defined Contribution 80**
☐ Defined Contribution Select*** $____________
☐ Traditional Contribution**** __________%

*Employer contributes $100 per employee per month.
**Employer contributes $80 per employee per month.
*** Employer selects contribution amount over $100 per employee per month.
**** Employer selects contribution amount of 50% or more per employee per month.

6B. EMPLOYER DENTAL CONTRIBUTION OPTION

Check one:
☐ Defined Contribution 15*
☐ Defined Contribution Select** $____________
☐ Traditional Contribution*** __________%

*Employer contributes $15 per employee per month.
**Employer selects contribution amount over $15 per employee per month.
***Employer selects contribution amount of 50% or more per employee per month.

6C. EMPLOYER LIFE CONTRIBUTION

☐ Employee Life Premium __________%

☐ Dependent Life Premium __________%

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.)

FOR UNICARE USE ONLY

DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

7. EMPLOYEE ELIGIBILITY

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

Number of full-time (usually 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 the waiting period.

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. Please note that under Texas law, partners and corporate officers, or members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances.

Name:	**Title:**	Exempt according to above requirements?
____________	____________	☐ Yes ☐ No
____________	____________	☐ Yes ☐ No

13. SIGNATURE AND CONDITIONAL RECEIPT

We, the employer, as administrator of an Employee Welfare Benefit Plan under 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 no coverage will be effective before the date determined by UNICARE. In addition, 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 reevaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms. We have provided the individual or the person through whom the individual was eligible to be covered as a dependent prior to declining coverage with an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose at the time of the individual's later decision to elect coverage, an exclusion from coverage until the next open enrollment period as well as a preexisting condition exclusion for twelve (12) months from the effective date of coverage, and received signed acknowledgement of the notice.**

ARBITRATION AGREEMENT: We understand that any dispute between us and UNICARE may be subject to binding arbitration, if both parties agree, and if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court. Under this coverage, if binding arbitration is agreed to by both parties, UNICARE Life & Health and we are giving up the right to have any dispute decided in a court of law before a jury.

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 herby 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 (Print or Type)	%	AGENT TAX I.D. NO.	(CHECK ONE) ☐ E = EIN ☐ S = SS#
AGENT ADDRESS		PHONE NO. ( )	FAX NO. ( )
CITY / STATE / ZIP			
SIGNATURE OF AGENT X			DATE
2. NAME OF ☐ SUB-AGENT ☐ SECOND WRITING AGENT (Print or Type)	%	AGENT TAX I.D. NO.	(CHECK ONE) ☐ E = EIN ☐ S = SS#
AGENT ADDRESS		PHONE NO. ( )	FAX NO. ( )
CITY / STATE / ZIP			
SIGNATURE OF SECOND AGENT X			DATE
3. NAME OF GENERAL AGENT		AGENT TAX I.D. NUMBER	

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