# New Business Checklist

Before a new business case will be processed and prior to receiving an effective date for acceptable 2–50 new business, UnitedHealthcare requires the completion of the following documents.

## Forms—Employer/Broker:

### UnitedHealthcare Group Application

Signature and date required by group and agent.

### Product Selection Form

Signature and date required by group.

## Forms—Member:

### Enrollment Spreadsheet

Enrollment forms not required if spreadsheet is used. Do not include waivers on spreadsheet.

### Member Enrollment Forms

Must be completed entirely. Date and signature are required.

COBRA enrollees are not counted as eligible employees when determining group size.

Waivers must be completed, signed and dated by the employee. Medicaid, Cost, Opt Out and Veterans Assistance are not considered valid waivers.

## Forms—Financial:

### Binder Check

Binder check with first month premium is required with application. Minimum employer contribution is 50 percent of the single employee rate on selected plan.

Include copy of check in the case-submission email.

See binder check coversheet for mailing address for actual check.

### Participation Certification

Groups of 10 or more may submit the Participation Certification in lieu of wage and tax documents.

## Forms—Financial: (continued)

### Wage and Tax Documents

If required to file a UCT-6, UnitedHealthcare requires all groups with up to 9 eligible employees to submit a signed copy of their current UCT-6/Quarterly Wage and Tax Report with their new business submissions.

If not required to file a UCT-6, the most current quarterly payroll statement, 1 document from (see below) Box A (if applicable for your business), and 1 from Box B are required to establish eligibility.

All tax documents must be a signed copy of the original document, or if submitted electronically, a copy of the document with a copy of the electronic acknowledgment.

| Box A | Box B |
|---|---|
| • Current business, state or occupations license<br>• Articles of incorporation<br>• Partnership agreements | • IRS Form 941 (not-for-profit use only)<br>• IRS Form 1040 (with a Schedule C or F)<br>• IRS Form 1065—Partnership Income (with K-1)<br>• IRS Form 1121/11205—Corporate Income (with K-1) |

Contact local Account Executive for Multi-site Guidelines.

If the 2-50 new business sold case submission guidelines are not met, the group may be required to move to the next effective date.

**For groups with PEO, Affiliate or Common Ownership, additional documentation may be needed.**

CONTINUED

UnitedHealthcare®

# Participation:

- 50 percent (less valid waivers) of all employees must participate.
- Groups with 2–3 eligible employees require the following: 100 percent participation of eligible employees. 100 percent employer contribution of employee premium.
- Eligible employees are those employees who are working a minimum of 25 hours per week and who have satisfied any waiting period as required by the employer. Employees in their waiting period are not eligible.
- When determining if adequate participation levels are met, UnitedHealthcare does not count as eligible any employee who has qualifying existing coverage in another employer- based group insurance plan or an ERISA qualified self-insured plan.
- Individual contractors paid by 1099 are eligible for coverage providing specific guidelines are met.

# Ancillary:

- UnitedHealthcare Insurance Company will be the sole carrier for **Dental and Life products.**
- The employer must meet the following **eligible employee participation and contribution** requirements for **Dental and Vision.**
  - **For contributory plans** — a minimum of 50 percent of the single premium rate and 75 percent participation.
  - **For voluntary plans** — a maximum contribution of 49 percent of the single premium rate and minimum 2 eligible with minimum participation of 2 enrolled for plans that do not include orthodontia. For plans that include orthodontia coverage there is a minimum of 10 eligible and 8 enrolled.
  - The employer must meet **eligible employee participation** requirement of 75 percent for contributory plans and a minimum contribution of 25 percent of the employee premium rate for Life. Employer must meet participation requirements of 100 percent for non-contributory plans.

# Submission deadline.

UnitedHealthcare may request additional documentation if needed to establish eligibility. All required information must be submitted to process the case by the requested effective date. Effective dates are the 1st and 15th of the month. Any cases with missing information may delay processing for the requested effective date.

**Please note:** Proposed rates are based on census data originally submitted and are valid only for those employees and dependents who reside or work in the designated service area. Final rates will be based on actual enrollment on the effective date of coverage. No group should cancel their coverage until they have received approval and final rates from UnitedHealthcare.

**For more information, please contact your local representative.**

**Orlando**
UnitedHealthcare
495 North Keller Rd. Suite 200
Maitland, Florida 32751

**Tampa**
UnitedHealthcare
9009 Corporate Lake Dr. Suite 200
Tampa, Florida 33634



UnitedHealthcare®

(DO NOT STAPLE)

# Employer Application for Small Business

**Florida** Please select one: Paper or Electronic invoices?

UnitedHealthcare®

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

☐ UnitedHealthcare Insurance Company
☐ UnitedHealthcare of Florida, Inc.
☐ Neighborhood Health Partnership, Inc.
☐ All Savers Insurance Company

Requested Effective Date

## General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable) | Internet access? ☐ Yes ☐ No

Contact Person | Email Address | # of Years in Business

Billing Address (If Different) | Telephone | Fax

Multi-Location Group* ☐ Yes ☐ No | # Locations | Address(es) (or list on additional sheet of paper)

*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Other_____
Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

Domestic Partner Coverage ☐ Yes ☐ No

Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days)
☐ 1st of Policy Month following Date of Hire
☐ 1st of Policy Month following ____ ☐ months ☐ days of employment
☐ Date of Hire (no waiting period)
☐ ____ ☐ months ☐ days of employment following Date of Hire

Waiting Period waived for initial enrollees ☐ Yes ☐ No

Nature of Business | Industry (SIC) Code

Have Workers' Comp ☐ Yes ☐ No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability:
☐ See Attached List ☐ None

| Participation | | # Employees Applying for: | | # Employees Waiving for: | | Contribution | Employer % | Employer % for Dep |
|---|---|---|---|---|---|---|---|---|
| # Eligible Employees | | Medical | | Medical | | Medical | | |
| # Ineligible Employees | | Dental | | Dental | | Dental | | |
| Total # Employees | | Vision | | Vision | | Vision | | |
| # Hours per week to be eligible – 25 | | Basic Life/AD&D | | Basic Life/AD&D | | Basic Life/AD&D | | |
| | | Dep Life | | Dep Life | | Dep Life | | |
| | | Supp Life/AD&D | | Supp Life/AD&D | | Supp Life/AD&D | | |
| For Disability products the minimum # of work hours per week to be eligible is 30 hours. | | Supp Dep Life/AD&D | | Supp Dep Life/AD&D | | Supp Dep Life/AD&D | | |
| | | STD | | STD | | STD | | |
| | | LTD | | LTD | | LTD | | |
| | | Other | | Other | | Other | | |

Note: Life insurance premiums for totally disabled insured are waived for 6 months.
☐ Yes ☐ No Acceptance of this application will replace existing life insurance coverage.

Coverage Provided by "UnitedHealthcare and Affiliates": Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare of Florida, Inc., Neighborhood Health Partnership, Inc. or All Savers Insurance Company. Dental, Vision, Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company

Group Name_____

## General Information (continued)

☐ Yes
☐ No

**Subject to ERISA? (Most private sector plans are ERISA plans)**

If No, please indicate appropriate category:

☐ Church (Additional information needed)
☐ Indian Tribe – Commercial Business
☐ Foreign Government/Foreign Embassy
☐ Federal Government
☐ Non-Federal Government (State, Local or Tribal Gov.)
☐ Non-ERISA Other _____

**UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage**

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

**Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?**

___ Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined on page 1).

___ No, we do not offer medical coverage during a leave of absence.

## Consumer Driven Health Plan Options

**Health Savings Account** (if selected): Which bank will be used: ☐ OptumBank ☐ Other

**Do you currently offer or intend to offer a Health Reimbursement Account (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.

## Questions Regarding Group Size

| | |
|---|---|
| ☐ COBRA<br>☐ State Continuation | Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year. If your group had fewer than 20 employees during a calendar year, you must provide State Continuation effective January 1 of the next calendar year. |
| ☐ Medicare Primary<br>☐ Plan Primary | Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status. |
| Enter the Prior Calendar Year Average Total Number of Employees<br>☐ | Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time**, part-time or seasonal status or whether or not they have medical coverage.<br>**A full-time employee is one who has a normal workweek of 25 or more hours.<br>To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges). |

Group Name_____

## Questions Regarding Group Size (continued)

| | |
|---|---|
| Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees<br>☐ | For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year.<br><br>In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year. |
| ☐ Yes<br>☐ No | Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)? |
| ☐ Yes<br>☐ No | Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?<br>If you answered Yes, then by signing this application you agree with the certification in this section.<br><br>I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy. |
| ☐ Yes<br>☐ No | Does your group sponsor a plan that covers employees of more than one employer?<br><br>If you answered Yes, then indicate which of the following most closely describes your plan:<br>☐ Professional Employer Organization (PEO) ☐ Governmental<br>☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Church<br>☐ Taft Hartley Union ☐ Employer Association |
| ☐ Yes<br>☐ No | Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses. |

## Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months? ☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

| | | Name of Carrier | Initial Coverage Begin Date | Coverage End Date |
|---|---|---|---|---|
| Current Medical Carrier | ☐ None | | | |
| Current Dental Carrier | ☐ None | | | |
| Current Life Carrier | ☐ None | | | |
| Current Disability Carrier | ☐ None | | | |
| Current Vision Carrier | ☐ None | | | |

Group Name_____

## Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees. This consent remains in effect until it is withdrawn. The Group may withdraw their consent at any time or request a document in a paper or non-electronic form.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes.

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, if applicable, are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

## Signature

| Group Authorized Signature | Title | Date |
|---|---|---|
| | | |

## Producer Information (if applicable)

| Writing Producer Name | Writing Producer SSN | | Is the Producer appointed with UHC? ☐ Yes ☐ No |
|---|---|---|---|
| All Payments to: | CRID Code (for internal use) | Tax ID# | If more than 1 Producer*, Split _____% |
| Street Address | City | State | Zip Code |
| Producer Phone # | Producer Email Address | Producer Fax Number | |
| Florida License ID # | ☐ Yes ☐ No To the best of my knowledge, acceptance of this application will replace existing life insurance coverage. | | |

| The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed. | **Producer Signature** | **Date** |
|---|---|---|
| | | |

*If more than one Producer, provide the second Producer's information on an additional sheet of paper.

## UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

## General Agent Information (if applicable)

| General Agent | Phone # | Franchise Code | |
|---|---|---|---|
| Street Address | City | State | Zip Code |
| | | | |

# Product and Benefit Selection Form

UnitedHealthcare

1a. Group Name _____

1b. Identify primary business location _____

1c. List all other locations besides primary business location _____

2. Medical Plan Code(s)

_____

_____

_____

_____

_____

2b. Will this plan co-exist with another health plan?

• Yes • No If yes, name of carrier _____

2c. Prescription Benefit Plan Number (Rx) _____

2d. Deductible Administration

• Calendar Year (from Jan. 1 to Dec. 31)

• Policy/Contract Year (from effective date to renewal date) [(Not applicable to NHP)]

I acknowledge that the health plan selected includes coverage for substance abuse and mental health that is equal to or exceeds coverage as required by Florida Statutes 627.669 and 627.668.

3. Dental Plan Code(s)

_____

_____

3b. Has this group been covered for major dental services for the previous 12 consecutive months?

• Yes • No If yes, name of carrier _____

4. Vision Plan Code(s)

_____

_____

5. Life Amount(s)

Employee $_____

Spouse $_____

Child(ren) $_____

• Yes • No Acceptance of this application will replace existing life insurance coverage.

6. Supplemental Coverage(s)

Life $_____

AD&D $_____

STD $_____

LTD $_____

7. Other Notes

YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

## Signature

| Employer Signature | Title | Date |
|---|---|---|
| | | |

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Life, Short -Term Disability (STD), Long-Term Disability Insurance coverage provided by UnitedHealthcare Insurance Company
Life Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

# Participation & Floor Certification

[Groups with 10+ Eligible Employees]

UnitedHealthcare®

| General Information | |
|---|---|
| Group's Legal Name | |
| Street Address | |
| Requested Effective Date | |

| Floor Calculation (AL, AR, AZ, DC, GA, IA, IL, IN, KS, KY, LA, MI, MN, MO, MS, ND, NV, OH, SD, TN, UT, VA, VT) | | |
|---|---|---|
| **1** | Number of employees enrolling in UnitedHealthcare group medical policy | |
| **2** | Number of eligible (full time) employees | |
| **3** | Divide line 1 by line 2. This is your **floor participation percentage.** | % |

| Participation Calculation (AK, CA, CO, CT, DE, FL, HI, ID, MA, MD, MT, NC, NE, NH, NJ, NM, NY, OK, OR, PA, RI, SC, TX, VI, WA, WV, WI, WY) | | |
|---|---|---|
| **1** | Number of eligible (full time) employees | |
| **2** | Number of eligible (full time) employees with a valid waiver reason | |
| **3** | Subtract line 2 from line 1. This is your **total eligible count.** | |
| **4** | Number of employees enrolling in UnitedHealthcare group medical policy | |
| **5** | Divide line 4 by line 3. This is your **participation percentage.** | % |

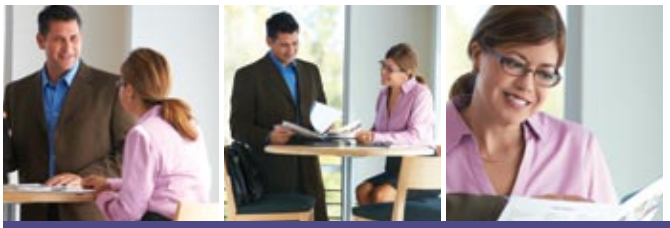
## Important Information

UnitedHealthcare reserves the right to review the applicant's payroll/wage & tax records at any time to confirm eligibility. UnitedHealthcare may request the applicant's most recent wage & 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.

## Signature

By signing this form, I hereby certify, as a condition of eligibility, that the Group is in compliance with the minimum participation requirements as expressed in the group policy. UnitedHealthcare reserves the right to request and review payroll or other documentation confirming compliance. I represent that the information I have provided is accurate and truthful. I understand that any intentional misrepresentation of material fact or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

| Group Authorized Signature | Title | Date |
|---|---|---|
| | | |



# Employer eServices Scheduled Direct Debit

**Sign up for UnitedHealthcare's Scheduled Direct Debit and have your premium payments automatically deducted from your bank account.**

If you're looking for new and better ways to help organize, streamline and generally make your job easier, there's no better place to start than with UnitedHealthcare's Scheduled Direct Debit.

That's because Scheduled Direct Debit is a safe, convenient and automatic way to pay your monthly insurance premiums.

All you do is sign up, then every month we automatically deduct your premium from your company's bank account.

Even better, Scheduled Direct Debit helps you better organize your payment records, streamlines your monthly invoice payment process and frees you up to get on with the business of your business.

**Enroll today in UnitedHealthcare's Scheduled Direct Debit program. Just fill in the simple form on the reverse side and return it to us. Do it today. And give yourself one less thing to worry about.**

## Scheduled Direct Debit:

- Lets you pay your premium at the same time each month.
- Provides predictable cash outflow.
- Gives you a consistent process for your premium payment.
- Provides an accurate record of your payment listed right on your bank statement.
- Means you'll never have to worry about missing an invoice or a deadline again. Everything's taken care of. Automatically.

*Get organized.*

*Get streamlined.*

*Get UnitedHealthcare's Scheduled Direct Debit.*

UnitedHealthcare®

# Scheduled Direct Debit Authorization Form

**Enrollment instructions**

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.
3. Fax this form to the fax number on the bottom of the authorization form.

**IMPORTANT: Please return the completed form along with a voided check (no deposit slips please.)**

**Statement of understanding**

By executing this document in the space provided below, I hereby confirm that I am authorized to act on behalf of the employer/customer ("Group") described below and agree on behalf of Group to the following terms and conditions:

- Group authorizes UnitedHealthcare to debit the group checking (account # provided below) for all monthly charges for coverage.
- Group understands that it may take up to one month to set up Scheduled Direct Debit and consequently all overdue premiums should be promptly paid in order to avoid receiving a delinquency letter and possible termination of your account during this initial set up period.
- Group understands and agrees that it will have sufficient funds in its account to cover the full premium invoice on the draft due date. If necessary funds are not in your account on the draft due date, group coverage may be subject to termination proceedings consistent with the terms stated in your UnitedHealthcare contract.
- Group agrees to promptly notify Unitedhealthcare of any change to the information provided.

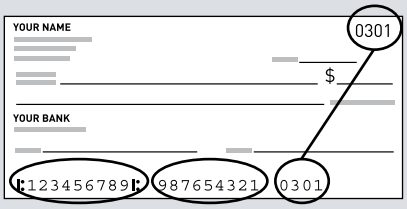
**Authorization**

Authorization is given to UnitedHealthcare to initiate debits (payments) to the financial institution indicated below. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above; or upon termination of coverage with UnitedHealthcare.

**Determining your routing number**

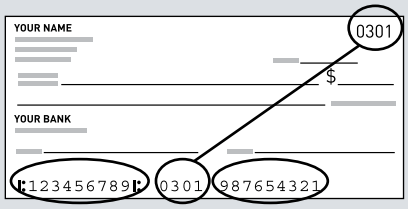
To determine your routing number, refer to your company check. **The routing number is always 9 digits long** and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank. For example:

Bank 1



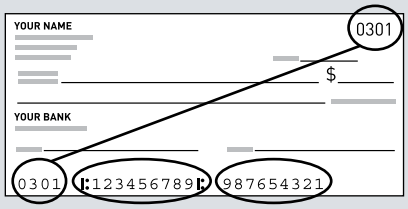

Routing # Account # Check #

Bank 2




Routing # Check # Account #

Bank 3




Check # Routing # Account #

If you are unsure what the routing number/transit number is, your bank can assist you.

**I have read and agree to the terms and conditions outlined above.**

Authorized signature and title of signatory

Date

Employer name/Customer name/Policy name

Employer email address

UnitedHealthcare customer number and bill group(s)

Name of your financial institution

Telephone number of financial institution

| Routing/Transit Number (9 Digits) | Account Number (include all zeroes and omit spaces/special characters) |
|---|---|
| | |

**Mail to:** UnitedHealthcare – Duluth
Attn: Accounts Receivable
MN 015-2838
4316 Rice Lake Rd.
Duluth, MN 55811

**OR**

**Fax to: 1-218-279-6493**
Attn: Accounts Receivable

# New Business Binder Check Coversheet

| | |
|---|---|
| **Group Name** | |
| **Federal TAX ID#** | |
| **Group Number** | |
| **Policy Eff Date** | |
| **Check #** | |
| **Amount#** | |

**Ensure check is written out to UHC**
**Include customer name & TAX ID # on check**
**Send check to below address**

| **Street Address:** | **Overnight Address:** |
|---|---|
| | |
| **UHS Premium billing**<br>**PO Box 94017**<br>**Palatine, IL 60094-4017** | **UHS Premium Billing**<br>**Attn: Box 94017**<br>**5505 N. Cumberland Ave. Suite 307**<br>**Chicago, IL 60656-1471** |

**** California Groups are sent to a different address.**

**Street Address:**
UHIC- UnitedHealthcare of California
PO Box 843118
Los Angeles, CA 90084-3118

**Overnight Address:**
UHIC- UnitedHealthcare of California
Wells Fargo Bank E2001-049
Lockbox 843118
3440 Flair Drive
El Monte, CA 91731