Health Addendum To Employer Application

For Rating Purposes

UnitedHealthcare
A UnitedHealth Group Company

Group Name:

Medical Profile (only for groups not requiring individual health statements)

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information. **Please provide details to "Yes" answers in the space provided. IMPORTANT:** Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No	1. Have any employees or dependents been diagnosed or treated during the past five years for: ☐ Cancer ☐ Immune Disorder ☐ Growth Hormones ☐ Tumor ☐ AIDS/HIV+ ☐ Transplants ☐ Heart/Circulatory ☐ Chronic Lung Disorder ☐ Hemophilia/Blood Disorders ☐ Stroke ☐ Kidney Disease/Failure ☐ Cerebral Palsy ☐ Reproductive Disorder ☐ Liver Disorders (Hepatitis) ☐ Sickle cell anemia ☐ Intestinal Disorder ☐ Back Disorder ☐ Immuno deficiency ☐ Endocrine Disorder ☐ Rheumatoid Arthritis ☐ Autism ☐ Diabetes ☐ Connective Tissue Disorder ☐ Brain/Nervous/Seizures ☐ Lupus ☐ Multiple Sclerosis ☐ Other Conditions _____
☐ Yes ☐ No	2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section.
☐ Yes ☐ No	3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years?
☐ Yes ☐ No	4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?
☐ Yes ☐ No	5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?
☐ Yes ☐ No	6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare?

If you answered "Yes" to any of the questions above, please provide the requested information for each individual.
If necessary, continue your comments on the back side of this form.

Question #	Check One Emp	Check One Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by UnitedHealthcare Insurance Company and its Affiliates ("UnitedHealthcare and Affiliates").

The Group shall notify UnitedHealthcare and Affiliates 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. Prior to receiving notification of approval, the Group shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent, including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

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, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy effective date, or other consequences.

Signature

Group Signature	Title	Date