

Key Account Insured Employer Application

UnitedHealthcare of Louisiana, Inc.



To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.
3. Include a deposit check in the amount of the first month's premium; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

Requested Effective Date _____

To be completed by UnitedHealthcare Account Executive

Product Selection (i.e. Choice, Choice Plus, Overture, etc.) _____

Medical Benefit Plan No. _____ Prescription Benefit Plan No. _____

Quoted Rates

Product	_____	_____	_____
Employee	_____	_____	_____
Employee+Spouse	_____	_____	_____
Employee+Child(ren)	_____	_____	_____
Family	_____	_____	_____
Dual Option Identifier	<input type="checkbox"/> Yes <input type="checkbox"/> No	Overture Product	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Overture Pkg.	_____

Ancillary Benefits

Mental health Benefits		
Full	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Limited	<input type="checkbox"/> Yes <input type="checkbox"/> No	
No Mental Health Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision Benefits		
Standard	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Quality	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Elite	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Outpatient Rehabilitative Benefits		
Physical, Occupational and Language Pathology Therapies		
No Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	

General Information

Group Name _____

Street Address _____ Tax ID _____

City _____ State _____ Zip Code _____ County _____

Contact Person _____ Telephone (____) _____ Fax (____) _____

Billing Address (if different) _____ Email Address _____

Multi-location group? Yes No # of Locations _____ Address (please list locations on additional sheet) _____

Years in Business _____ Nature of Business _____ Industry Code _____

Number of employees/dependents currently on COBRA/Continuation _____ Total # Employees _____ # Full Time Employees _____ # Part Time Employees _____

Applying (Please include those employees in their waiting period) _____ # Waiving _____ # Hours per week to be Considered Eligible _____

Termined in 12 months _____ Wait Period for New Hires First of the Month Following _____ Days of Employment _____

Name of Current Medical Carrier _____ # Yrs with the Current Carrier _____ Name of Current Dental Carrier _____ # Yrs with the Current Carrier _____

Employer Contribution – Single _____ % Employer Contribution – Single _____ % Classes Excluded Union/Non Union
Medical Family _____ % Dental Family _____ % Other _____

Worker's Comp Carrier _____ List Owners/Partners not covered by Workers Compensation _____

Yes No In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

Yes No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be placed voluntarily into bankruptcy?

Broker Information

Broker Name		Agency		Agent Code/Tax ID Number	
Signature		Email Address	Social Security #		Phone Number
Rep Name			Rep #		
Commissions payable to			Broker Commission Schedule _____ Std Scale of _____ %		

Medical Profile

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). 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. Are any eligible employees or dependents receiving disability benefits of any type including Short Term Disability, Long Term Disability, Social Security Disability Income, Workers Compensation, Medicare, Medicaid or on extended leave due to injury, disability or illness?
- Yes No 2. Are any employees or dependents contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and/or surgery?
- Yes No 3. Have any eligible employees or dependents had large claims in excess of \$10,000, or do you anticipate any large claims?

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check One		Age	Date of Recovery	Date of Treatment/Condition	Nature of Medication	Name of Condition	\$ Amount of Claims	Prognosis Current Treatment
	Employee	Dependent							

The Company certifies that the information provided above is complete and accurate. Company shall notify the Insurer 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, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer 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 this Policy.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Company's employees.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature (Form must be signed)

Client Signature _____ Date _____ Title _____
 (Owner or Officer of Firm)

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