

## Employer **Form** Help Sheet

### The Following Fields Are Mandatory For Installing a Group\*

Requested Effective Date	Group Name	Complete Address and Tax ID
Contact Person/Telephone #	Billing Address	Medicare Primary/Health Plan Primary
Nature of Business	Type of Organization	Waiting Period for New Hires
Date of Event	Hours Worked	Name of Current Carrier/Years Covered
Employer Contribution/Medical	Classes Excluded	COBRA Continuation/State Continuation
		Waiting Period Waived at Initial Enrollment

\*If any of the above fields are missed, a delay in processing the group will occur

**Requested Effective Date** – Enter the requested effective date for this group. NOTE: This is the date the employer is requesting coverage to become effective. This is not the final effective date as assigned by Underwriting.

### General Information

**Group Name** – The legal name of the business is required in this field. NOTE: This is not DBA. The legal name can be found on the company's tax forms.

**Group Address** – Enter the physical address of the business. You must include City, State and Zip Code. NOTE: PO Box is not acceptable in this field.

**Email Address** – Enter the Email address of the group. This cannot be the broker's Email address. (Please indicate if the group does not have an Email address.) This information will enable the group to receive communications and process eligibility and billing requests online. NOTE: This information is not sold to other companies.

**Billing Address** (if different) – Enter the Billing Address. If the business receives mail at a Post Office Box, enter that information here.

**Industry Code** – Enter the Standard Industry Code (SIC) of the business.

**Organization Type** – Check one that applies to this business. Please indicate type if "other." NOTE: The Organization Type determines the type of Tax documentation that is required.

**Nature of Business** – Enter the nature of the business conducted by this employer. This should coincide with the industry code. (This will differ by state.)

**Waiting Period for New Hires** – Enter the employer's choice of waiting periods for new hires. (This will differ by state.) NOTE: "First of the month" refers to the first day of the policy month.

**Date of Event** – If this is checked, the new member's coverage is effective as of their date of event (i.e. date of hire). If there is a waiting period, the new member's coverage is typically effective 30, 60, or 90 days from their date of event.

**Have Workers' Comp** – Check "yes" or "no."

**List Owner's/Partner's not covered by Workers' Comp** – List all employees not covered by Workers' Comp. NOTE: The field is labeled for "Owners/Partners" because most states require all employees, with the exception of Owners and Partners, to be covered by Workers' Comp. There are however, some states that allow smaller businesses to opt out of Workers' Comp. for their employees. In these situations, all employees not covered by Workers' Comp must be listed in this field.

**Waiting Period Waived at Initial Enrollment** – Choose either "yes" or "no." NOTE: The employer has the option of waiving the new hire waiting period for current employees that would normally be ineligible because they are currently in the new hire waiting period. This is a one-time option and only applies to new employees at the time the

entire group enrolls for coverage.

**Classes Excluded** (Union/Non-Union and Other) – Check “None”, “Union”, or “Other” NOTE: If “Other” is checked, please provide details.

## Participation Information

**Number of Hours (worked) Per Week to be Eligible** – Enter the number of hours the employee must work to be considered eligible for coverage. NOTE: There are state laws governing the minimum number of hours an employee must work to be considered eligible for benefits. In most cases, the minimum number of hours is 30. And, in the event the state does not specify, standard UnitedHealthcare policy is 30 hours.

**Number of Full / Number of Part Time Employees** – Enter the total number of full time and part time employees, in all locations, for this employer.

**Number of Ineligible Employees** – Enter the total number of ineligible employees. NOTE: This number does not include those who are ineligible solely because they are Part Time (PT), as those employees have been counted in the field designated for PT Employees.

**Total Employees** – Enter the total number of employees (Full Time, Part Time and Ineligible).

**Number Applying / Waiving for Health, Life, Dental, Vision and Other** – Enter the total number of employees choosing to apply and waive for Health, Life, Dental, Vision and Other optional benefits each separately. NOTE: If the employer is not offering Life, Dental, Vision or Other optional benefits to their employees, enter “N/A” in the field next to the specific type of benefit.

## Contribution Information

**Employer / Employee Contribution % for Health, Life, Dental, Vision and Other** – Enter the percentage of premium the employer and employee are contributing toward the cost of the employee’s Health, Life, Dental, Vision and Other optional benefits. The minimum employer contribution for each employee is 50% unless mandated by the state. NOTE: The employer and employee contribution percentages should add up to 100%. If the employer is not offering Life, Dental, Vision, or Other optional benefits, enter “N/A” in this field.

**Employer Contribution % for Dependent Health, Life, Dental, Vision and Other** – Enter the percentage of premium the employer is contributing toward the cost of the dependent’s Health, Life, Dental, Vision and Other optional benefits.

**Name of current carrier for Health, Life, Dental, Vision and Other** – Enter the name of the group’s current carrier(s) for Health, Life, Dental, Vision and Other optional benefits. NOTE: If the employer is not currently offering Health, Life, Dental, Vision and Other optional benefits, enter “None” in these fields.

## Questions Regarding Group Size

**COBRA or State Continuation** – This question refers to the legal size of the group. Check appropriate box based on definitions provided on application. NOTE: The legal size of a group includes all employees, (FT and PT) not just those electing coverage.

**Medicare or (Health) Plan Primary** – This question refers to the legal size of the group. Check appropriate box based on definitions provided on application. NOTE: The legal size of a group includes all employees, (FT and PT) not just those electing coverage.

**Member of a “controlled group of corporations”** – If this group is one of two or more corporations that are able to file taxes together as one entity, check “yes.”