

Employer Application for Large Group

Groups with 51 or more Eligible Employees



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 any required premiums; 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.

General Information

Requested Effective Date 10/1/16

Group's/Company's Legal Name

Southside Cleaners dba Oceanside Cleaners

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

Street Address

3742 Southside Blvd.

Tax ID

59-2994476

City

Jacksonville

State

FL

Zip Code

32216

Names of Owners/Partners (if applicable)

Mike & Amy Harris

Internet Access?

Yes No

Contact Person

Amy Harris

Email Address

amy@oceansidecleaners.com

of Years in Business

25

Billing Address (if different)

Telephone

904-591-6198

Fax

904-280-0606

Multi-location group/company?*

Yes No

of Locations

2

Address (es) (or list on additional sheet of paper)

298 Solano Rd. Ponte Vedra Beach, FL 32082

Organization Type

Partnership C-Corp S-Corp LLC/LLP

Nature of Business

Dry Cleaners

Industry Code

7212

Waiting Period for new hires

1st of Policy Month following Date of Hire

1st of Policy Month following 60 months 7 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

Medical Benefit Plan Option

Calendar Year

Policy Year***

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)

0

Number of Employees Termined in last 12 Months

34

Classes Excluded:

None Union Hourly Non-Management Salary

Have Workers' Comp?

Yes No

Name of Workers' Compensation Carrier

Employers Assurance Company

Domestic Partner Coverage?

Yes No

Names of Owners/Partners not covered by Workers' Compensation

Michael HARRIS, Amy HARRIS

By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

*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.

| Participation | # Employees Applying for: | # Employees Waiving for: | Contribution | Employer % | Employer % for Dep |
|--|---------------------------|--------------------------|--------------------|------------|--------------------|
| # Eligible Employees | <u>65</u> | <u>32</u> | Medical | <u>50</u> | <u>0</u> |
| # Ineligible Employees | <u>13</u> | | Dental | | |
| Total # Employees | <u>78</u> | | Vision | | |
| # Hours per week to be eligible <u>30</u> | Basic EE Life/AD&D | Basic EE Life/AD&D | Basic EE Life/AD&D | | |
| # Hours per week to be eligible for Disability coverage if different from above ** | Basic Dep Life | Basic Dep Life | Basic Dep Life | | |
| | Supp EE Life/AD&D | Supp EE Life/AD&D | Supp EE Life/AD&D | | |
| | Supp Dep Life/AD&D | Supp Dep Life/AD&D | Supp Dep Life/AD&D | | |
| | STD | STD | STD | | |
| | STD Buy Up**** | STD Buy Up**** | STD Buy Up**** | | |
| | LTD | LTD | LTD | | |
| | LTD Buy Up**** | LTD Buy Up**** | LTD Buy Up**** | | |
| | 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 coverage provided by UnitedHealthcare Insurance Company

Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company

Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

Enter the Prior Calendar Year Average Total Number of Employees

74

Note: Only applies to groups with less than 100 Eligible Employees

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.

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).

Yes No Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

Yes No Subject to ERISA?
If No, please indicate appropriate category:
 Church Federal Government
 Indian Tribe – Commercial Business Non-Federal Government (State, Local or Tribal Gov.)
 Foreign Government/Foreign Embassy Non-ERISA Other

Yes No In the past 36 months, has the Group/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 Group/Company or any affiliated entity be placed voluntarily into bankruptcy?

Yes No Does your group sponsor a plan that covers employees of more than one employer?
If you answered Yes, then indicate which of the following most closely describes your plan:
 Professional Employer Organization (PEO) Multiple Employer Welfare Arrangement (MEWA)
 Taft Hartley Union Governmental
 Church Employer Association

Yes 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)?
If you answered Yes, then by signing this application you agree with the certification in this section.
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 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)?

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence?

(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

- Last Day worked (following the last day worked for the minimum hours required to be eligible)
- 3 Months (following the last day worked for the minimum hours required to be eligible)
- 6 Months (following the last day worked for the minimum hours required to be eligible)
- UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
- No, we do not offer medical coverage during a leave of absence

***UnitedHealthcare Special Provisions Related to Medical Eligibility Note: This does not apply to NHP.**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, 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.

HRA and Supplemental Insurance Information

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.

HRA/HSA Employer Premium Contribution

| | Option #1 | Option #2 | Option #3 |
|-----------------------|-----------|-----------|-----------|
| Medical Plan | N/A | | |
| Employee | | | |
| Employee + Spouse | | | |
| Employee + Child(ren) | | | |
| Family | | | |

HRA/HSA Employer Account Funding Amount

| | | | |
|-----------------------|--|--|--|
| Employee | | | |
| Employee + Spouse | | | |
| Employee + Child(ren) | | | |
| Family | | | |

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? Yes No

Who will provide account balances to UnitedHealthcare?

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 | Coverage Begin Date | Coverage End Date |
|----------------------------|-------------------------------|-----------------|---------------------|-------------------|
| Current Medical Carrier | <input type="checkbox"/> None | Aetna | 10/1/13 | 9/30/16 |
| Current Dental Carrier | <input type="checkbox"/> None | | | |
| Current Life Carrier | <input type="checkbox"/> None | | | |
| Current Disability Carrier | <input type="checkbox"/> None | | | |

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents 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
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?
 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?
 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?
 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?
 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?
 6. Is any employee or dependent currently hospitalized?
 7. Within the past 3 years has any employee or dependent been diagnosed by, treated by, or received prescription medication from a licensed member of the medical profession for any of the following conditions?
 - Cancer (any type)
 - Lung disease or respiratory problem (any type)
 - Heart disease or disorder (any type)
 - Organ, tissue or cell transplant
 - Liver disease (any type)
 - Kidney disease (any type)
 - Pancreatic disorder (any type)
 - Diabetes
 - Hepatitis
 - Morbid obesity
 - Congenital abnormality
 - Vascular disease (any type)
 - Neurological disorder (any type)
 - Immunological disorder (reportable types)
 - Alcohol or drug addiction or abuse
 - Hemophilia or Blood disorder (any type)

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

Additional information is not required for conditions related to HIV/AIDS/ARC.

Disclosures (continued)

| Question Number | Check One Employee Dependent | Age | Date of Recovery | Date of Treatment/ Condition | Nature of Medication | Name of Condition | \$ Amount of Claims | Current Treatment |
|-----------------|-----------------------------------|-----|------------------|---------------------------------|----------------------|-------------------|---------------------|-------------------|
| 1 | ✓ | 51 | 3/17/16 | 7-28-15 | UNKNOWN | Frozen Shoulder | UN KNOWN | None |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company 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/Company 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 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 the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's employees.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:

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 (Form must be signed)

Group/Company Signature *[Signature]* Date 7-20-16 Title Vice President

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL

Producer Information (if applicable)

| | | | | | |
|---|---|---|-------------------------------------|---|--|
| Producer Name <u>M. Lynn Turner</u> | | Agency <u>Plan Analysts</u> | | Agent Code/Tax ID Number <u>59-2463591</u> | |
| Signature <u>Lynn Turner</u> | Email Address <u>Lturner@plananalysts.com</u> | Social Security # | Phone Number <u>904-954-8989</u> | Date | |
| Florida License ID# <u>A269598</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No To the best of my knowledge, acceptance of this application will replace existing life insurance coverage. | | | | |
| All Payments to: <u>Plan Analysts</u> | | Producer Commission Schedule (if applicable) _____ Std Scale of _____ % | | | |
| Street Address <u>1 Independent Dr. # 3125</u> | | City <u>Jacksonville</u> | State <u>FL</u> | Zip Code <u>32202</u> | |
| Rep Name <u>Jess Adams</u> | | Rep # | | | |

General Agent Information

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