

Small Business Group Acceptance/Change Form



Effective October 1, 2008

Please indicate reason for change: New Business: <input type="checkbox"/> Acceptance of new coverage Renewals: <input type="checkbox"/> Acceptance of renewal with new renewal rates: Group # _____ <input type="checkbox"/> Change existing coverage: Group # _____	Source Code Tracking #
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Important: Please Print or Type All Sections in Black Ink

Legal Name of Group/DBA	Telephone ()	Fax ()		
Address	City	County	State	ZIP

Employer Contribution (Medical Only): Employee Premium = _____% Dependent Premium = _____%

Total Permanent Full-Time Employees: <i>(working 30 or more hours per week)</i>	Total Permanent Part-Time Employees: <i>(working 20–29 hours per week)</i>	Do you wish to offer coverage to ALL employees working 20–29 hours per week? <input type="checkbox"/> Yes Effective Date _____ <input type="checkbox"/> No
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Please Indicate New or Changed Coverage Below

Plan of Coverage – All UnitedHealthcare plans are underwritten by United HealthCare Insurance Company.

Please Select All Medical Plans for the Contract Year

Groups enrolling less than five active employees may select one plan from the following list. Groups enrolling five or more active employees may select up to four medical plans; up to two may be from the following list of UnitedHealthcare plans. Please make your PacifiCare benefit selections on the PacifiCare Group Acceptance Form. Plan(s) indicated with an asterisk (*) are only available on a standalone basis. Calendar and Policy Years may not be combined.

Would you like to select a Calendar Year or Policy Year plan? Calendar Year Policy Year

UnitedHealthcare Choice Plus DefinitySM Health Savings Account (HSA) Plans 2000/100% <input type="checkbox"/> Plan 7A-T ¹ 1500/80% <input type="checkbox"/> Plan U1-O ¹ 2850/80% <input type="checkbox"/> Plan 6C-L ¹ 2850/80% <input type="checkbox"/> Plan 6C-K 3500/70% <input type="checkbox"/> Plan 6C-J ¹ 3000/70% <input type="checkbox"/> Plan 6C-I UnitedHealthcare Choice Plus Consumer (HRA) Plans 1500/100% <input type="checkbox"/> Plan 7A-L 2000/100% <input type="checkbox"/> Plan 7A-M 1500/80% <input type="checkbox"/> Plan 6C-H 2500/80% <input type="checkbox"/> Plan S1-Y 3000/70% <input type="checkbox"/> Plan 6C-G	UnitedHealthcare Choice Plus Traditional with Deductible Plans 20/250/90% <input type="checkbox"/> Plan 6C-M 35/500/80% <input type="checkbox"/> Plan 6C-D 30/500/70% <input type="checkbox"/> Plan 6C-B UnitedHealthcare Choice Plus Balanced 100 Plan 30/3000/100% <input type="checkbox"/> Plan 6C-X <input type="checkbox"/> Value Plan 6C-O UnitedHealthcare Choice Plus Balanced Plans 25/1000/80% <input type="checkbox"/> Plan 6C-W <input type="checkbox"/> Value Plan 6C-P 25/2500/80% <input type="checkbox"/> Plan 6C-V <input type="checkbox"/> Value Plan 6C-Q 35/1000/70% <input type="checkbox"/> Plan 6C-C <input type="checkbox"/> Value Plan 6C-R 40/1500/70% <input type="checkbox"/> Plan 6C-F <input type="checkbox"/> Value Plan 6C-S 35/1000/50% <input type="checkbox"/> Plan 6C-E <input type="checkbox"/> Value Plan 6C-T 35/2000/50% <input type="checkbox"/> Plan 6C-N <input type="checkbox"/> Value Plan 6C-U UnitedHealthcare Non-Differential PPO Plan 2000/80% <input type="checkbox"/> Plan 6H-E*
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Please answer the following question:

Will you self-fund any portion of your employees' cost-sharing by offering a wraparound plan, such as a Health Reimbursement Account (HRA), in addition to your UnitedHealthcare Small Business plan? Yes No If No, and group does not disclose that they have a wraparound plan or adds one after the initial group enrollment, the group may be subject to re-rate or termination.

Supplemental Benefits Group Term Life <input type="checkbox"/> Add ² <input type="checkbox"/> Cancel <input type="checkbox"/> Renew <input type="checkbox"/> Change ²	Other Coverage (required) Domestic Partners Coverage All UnitedHealthcare plans include Domestic Partner coverage as required by state law.
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¹ The annual family deductible for this plan does not include an embedded individual deductible.
² Separate application required.

The undersigned is authorized by the above Small Employer Group to apply for or change group coverage offered by United HealthCare Insurance Company at the attached premium rates guaranteed for 12 months effective _____ and is authorized to enter into a Medical and Hospital Group Master Policy.
 Further, the undersigned agrees to make full monthly premium payments to UnitedHealthcare for the benefits received in accordance with the terms of the contract.

Authorized Signature	Date
Print Name	Title

For renewals only, please fax to **Account Management Team Fax # 1-800-926-2951**

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

UNDERWRITING APPROVAL	D.P. Only
INTERNAL USE ONLY: G.C. #	