For use with groups installed on the

PRIME PLATFORM

Note: Franchise Code, if needed, should be entered in the GA Override field of the General Agent Information Section.

For Office Use Only: PRIME Platform

Specialty Combined Group Application

COMPANIES:

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
2950 Express Drive South, Suite 240, Islandia, NY 11749-1412
Products: Group Dental Insurance, Vision Care Insurance

UNIMERICA LIFE INSURANCE COMPANY OF NEW YORK
One Penn Plaza,- 8th Floor, New York, NY 10119-0899
Products: Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, and Long Term Disability Insurance

Requested Effective Date of Coverage: _____/_____/_____

GENERAL INFORMATION

Group's Full Legal Name:				
Group Name as it will Appear on Dental and Vision ID Cards (Max 30 characters):				
Street Address:		City:	State:	Zip Code:
Contact Name:	Phone Number:	Fax Number:	E-Mail:	
Billing Address (If Different):				
Billing Contact:		Billing Contact Phone:		
Tax ID Number:	Number of Years in Existence:	Is the group subject to ERISA? ☐ Yes ☐ No		
Nature of Business/Organization:	Industry Code (SIC):	List all subsidiaries to be included:		
Multi Location Group? ☐ Yes ☐ No	Number of Locations:	List Locations:		

Organization Type: ☐ Corporation ☐ Partnership ☐ Political Subdivision ☐ Sole Proprietor ☐ Other*: _____
*Other group types may be subject to regulatory approval.

Names Of Owners/Partners:

Did you employ anyone other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners ☐ Other Excluded Class _____

Will there be an Eligibility Waiting Period for New Hires? ☐Yes ☐No

If yes, fill in: _____ days of employment from the date of hire; or _____ months of employment from the date of hire; or 1st of month following _____days of employment; or 1st of month following _____months of employment.

Waiving the initial waiting period ☐Yes ☐No

ELIGIBILITY / PARTICIPATION

Total Number of Eligible Employees:		Minimum # of hours worked per week to be eligible for coverage	
Total Number of full-time Employees:		Minimum # of hours worked per week to be eligible for Disability coverage if different from the above*	

*For disability products the minimum # of hours per week to be eligible is 30 hours.

PLAN SELECTION AND INFORMATION

Products	Check your selection and fill in the Amount or Plan Code	% Premium contribution by Group	
		Employee	Dependents
Dental	☐ _____	_____%	_____%
Vision	☐ _____	_____%	_____%
Group Life			
• Basic Life / AD&D	☐ _____	_____%	N/A
• Supplemental Life / AD&D	☐ _____	_____%	N/A
• Basic Dependent Life / AD&D	☐ _____	N/A	_____%
• Supplemental Dependent Life / AD&D	☐ _____	N/A	_____%
Short Term Disability	☐ Core	_____%	N/A
	☐ Buy up	_____%	N/A
Long Term Disability	☐ Core	_____%	N/A
	☐ Buy up	_____%	N/A

For Dental or Vision Coverage: ☐ COBRA or ☐ State Continuation
If checked, provide total # of COBRA / Continuation participants in total group?

REPLACEMENT / PRIOR COVERAGE INFORMATION

Products	Do you intend to use this policy to replace a similar plan?	Prior Carrier's Name	Prior Policy #	Termination Date
Dental	☐ Yes* ☐ No			
Vision	☐ Yes ☐ No			
Group Life	☐ Yes ☐ No			
Short Term Disability	☐ Yes ☐ No			
Long Term Disability	☐ Yes ☐ No			

* If Dental Coverage is being replaced, was prior dental policy in force for the past 12 consecutive months? ☐ Yes ☐ No

PRODUCER INFORMATION

Producer Name:		Agency:	
Producer Signature:		Date:	
Street Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:	
Producer Number:	Tax ID Number:		
Commissions Payable To:		Commission split % (if applicable):	

Note: **Provide information in a separate sheet if more than one producer.**

GENERAL AGENT INFORMATION

General Agent Name:		Tax ID Number:	
Street Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:	
Commissions Payable To:		G.A. Override:	

PRODUCER COMPENSATION DISCLOSURE

DISCLOSURE REGARDING PRODUCER COMPENSATION:
In some cases, we pay brokers and agents (commonly known as "producers") compensation for their services when they sell our products, in compliance with applicable law. In some states, we may pay "base commissions" based on factors such as: product type; amount of premium; group or company size; and number of employees. These base commissions are reflected in the premium rate.

We may also pay bonuses under programs designed to encourage the placement 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 ate. They are included as part of the general administrative costs. We also from time to time, pay producers for services other than those relating to the sale of policies. For example, we pay 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 federal law. For information about the compensation that may be paid with respect to your policy, please contact your producer.

AGREEMENT

The Group and the Company(ies) ("we", "us" or "our") agree that:

THE APPLICATION shall become part of any policy issued.

PREMIUM RATES shall: (1) be subject to all provisions in that policy; and (2) be binding on both Employer and us.

LIABILITY OF THE COMPANY(IES). We will have no liability until this request has been approved at Our Administrative Office.

AUTHORITY OF AGENTS. No agent can change the terms of this requestor any policy we issue. No agent can waive any of our rights, requirements or extend the time for any premium payments.

CHANGES AND CORRECTIONS. Changes are an amendment to and form a part of the original request and any policy issued. No change in the policy shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer. No application shall contain a provision which changes the terms of the policy to which it is attached.

I UNDERSTAND AND AGREE that:
- the 1st month's estimated premium and complete enrollment information for all eligible persons requesting coverage; must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notice of acceptance from the Company(ies). If my coverage is declined, the Company(ies) will return the premium deposit given with the Application. If my coverage is approved, premium must be paid monthly in advance.
- I am responsible for sending notice to the Company(ies) promptly of any changes in information that affects the eligibility of employees or members or their dependents. This includes the addition of newly eligible employees or members or dependents.
- the Policy/Certificate of Coverage or Summary Plan Description, other documents, notices and communications regarding the coverage indicated on this Application, may be transmitted electronically to me and to the Group's employees or members. The Employer has the option to request that the Company(ies) provide the Policy/Certificate of Coverage or Summary Plan Description, other documents, notices and communications regarding the coverage in print rather than electronically. Delivery method preference is requested within the Group Signature section.

I declare that all the statements made in this Application are, to the best of my knowledge: true and complete. I understand that the Company(ies) will rely on the information I provide to determine: eligibility for coverage; setting premium rates; and other purposes, and that the Policy is incontestable after two years except for the non-payment of premium. I agree that the Company(ies) will rely on the most current information it has with respect to the eligibility of employees or members and their dependents in providing coverage under this policy.

The following notice(s) do(es) not apply to life insurance coverage: INSURANCE FOR SHORT TERM DISABILITY AND/OR LONG TERM DISABILITY MAY CONTAIN A PRE-EXISTING CONDITION LIMITATION/EXCLUSION. PLEASE SEE THE POLICY(IES) FOR MORE INFORMATION.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

GROUP SIGNATURE (form must be signed)

Policy/Certificate of Coverage or Summary Plan Description, other documents, notices and communications delivery preference to the Employer (if option not elected, Print will be the default delivery method)	☐ Electronic Delivery ☐ Print
Group Authorized Person's Name (Print):	Title:
Group Authorized Person's Signature:	Date:

FRAUD WARNING NOTICES

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For residents of California (Health products): UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For residents of California (Life products): For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: 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.

For residents of Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

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

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: 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 civil fines and criminal penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated State law.

For residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states: 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.