UnitedHealthcare Oxford

Employer Information Form

Employer (legal) Name & DBAs:	**Customer/Group#:**
Federal Employer Identification Number (EIN):	**Nature of Business (product sold/service provided):**
Physical Address:	**Website (If applicable):**
Telephone Number **( )**	**Email Address:**

SECTION A: TYPE OF BUSINESS ORGANIZATION FOR FEDERAL TAX PURPOSES

Please check one

❑ **Sole Proprietor**	❑ **C-Corporation**	❑ **S-Corporation**	❑ **Partnership/LLP**	❑ **Non-Profit**	❑ **LLC**

SECTION B: ELIGIBILITY REQUIREMENTS

Please answer the following questions to assist us in determining your eligibility.

1. Is the group maintaining the minimum contribution requirement defined in your Group Policy? *Refers to the amount of employee's premium paid by the employer.	❑ Yes ❑ No
2. Does the business have any owners or employees not listed on the quarterly wage and tax statement? *If yes, please provide a copy of the most recent ownership documents for all owners, confirming 100% ownership. See page 2 for common documents for each entity type. **If no, please indicate which employees are owners on the quarterly wage and tax statement	❑ Yes ❑ No
3. Is your group a Professional Employer Organization (PEO), Employee Leasing Company (ELC), or other such entity that is a co-employer, with your client(s), of client-site employees? *If yes, then by signing this form, you agree with the following certification: 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. I understand that UnitedHealthcare will not cover the co-employees under this group policy.	❑ Yes ❑ No
4. Does the business have any employees other than the owner and owner's spouse?	❑ Yes ❑ No
5. I attest that all covered employees are currently working the minimum required number of hours each week to be eligible.	❑ Yes ❑ No

SECTION C: CERTIFICATION

The undersigned certifies that the foregoing information is true, correct and complete, and fully understands that any false statements or failure to provide all available information may constitute the basis for rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Name (please print) **& Title** **Signature:** **Date:**

SECTION D: WAGE AND TAX DOCUMENTATION

Please provide a copy of the most recent quarterly wage and tax statement filed with your state. This report is filed on a quarterly basis and lists all W2 employees for unemployment tax purposes. Review the list of documents below and provide supporting documentation based on your employees and business type.

In order to validate full-time employment and eligibility for coverage, do not black out earnings information. If you prefer, you may black out part of the Social Security Number, but leave at least the last 4 digits for identification verification.

Sole Proprietor	IRS 1040 Schedule C
S-Corporation	IRS Schedule K-1 for each owner, totaling 100% (Form 1120S Corporation Filing)
C-Corporation	IRS Form 1120 Corporation Filing - Page 1 and 2; Schedule G, or Form 1125-E
Partnership/LLP	IRS Schedule K-1 for each partner, totaling 100% (Form 1065)
LLC	IRS 1040 Schedule C or Schedule K-1 totaling 100%
Non-Profit	Most recent Federal Form 941 and most recent 2-week payroll identifying all employees, earnings, average hours worked each week, and date of hire.
Government Entity	Most recent 2-week payroll identifying all employees and earnings
Household	IRS 1040 Schedule H
Farm	IRS 1040 Schedule F
Contracted Employee	IRS Form 1099-NEC for all contracted employees offered coverage; Copy of Independent Contractor Agreement; Common Law Employee and Fact Attestation Form; and most recent 12 weeks of payment records indicating earnings, average hours worked each week, and date of hire.
New Hire	Most recent 2-week payroll report identifying all employees, earnings, average hours worked each week, and date of hire.
Spouse of Owner	Most recent quarterly wage and tax statement indicating earnings.
If group is on Extension	IRS Form 4868 or Form 7004 and the previous year's tax documentation last filed.

SECTION E: INFORMATION TO ADD TO THE WAGE AND TAX DOCUMENTATION

- Review the Status Code chart below based on the **current employment status of all employees**.
- **Next to each employee**, directly on the state quarterly wage and tax report, ownership documentation, payroll, 1099-NEC forms etc. include:
    - **Status code based on employee's current employment status**
    - **Information underlined within the Status Code details**
    - **Verify if an Owner**

Please note that you must include the status code and all information pertaining to that status code for consideration of eligibility.

A	**Actively Enrolled Plan Participant**	**MC**	**Medicare**
CO	**COBRA/Continuation** Indicate continuation start date and whether coverage is provided by a prior employer or by your company. If by this employer, please provide the last quarterly wage & tax report they appeared as a full-time employee earning full-time wages for the entire quarter and confirm the last date of employment.	**LA**	**Leave of Absence** Indicate the last date worked and when expected back to work. Also provide the last payroll reflecting full-time hours.
CH	**Champus**	**TR**	**Terminated Employee** Indicate date of termination.
GR	**Group Coverage** Indicate if the coverage is sponsored by this employer or through another employer.	**DE**	**Declined (i.e. Declined coverage due to cost or does not want)** Only use this code if the employee is full time with no other coverage or waiver reason.
ID	**Individual Coverage**	**VA**	**Veterans Administration Coverage**
SP	**Spouse's Employer Sponsored Plan**	**UC**	**Union Coverage**
PT	**Part Time Employee** Not working full-time hours and not eligible for coverage. Includes temporary employees.	**WP**	**Waiting Period** Indicate date of hire and date employee will be eligible for coverage.
MD	**Medicaid**	**TC**	**Tricare**
PC	**Parental Coverage**		

RISK MANAGEMENT CONTACT INFORMATION

Include your Group Number on all correspondences. Please visit our website for FAQ's and to check the status of your eligibility verification audit submission.

Website	www.uhc.com/rm	**Email**	risk.management@uhc.com
Toll-Free Phone Number	1-877-504-1179	**Fax Number**	1-877-232-7902

Common Ownership Certification

UnitedHealthcare Oxford

Please complete, sign and submit the Common Ownership Certification.

Renewing Groups- complete and return even if you do not have multiple companies.

Please list all companies that are eligible to be included as part of a consolidated federal tax return (even if they don't file a consolidated federal tax return) or who are part of a controlled group as defined under the Internal Revenue Code. *When listing the number of Eligible, count the number of Eligible employees for each business, even if they're not offered this insurance.

Customer Name: _____

Group Number (if renewal):

Primary Business Location: _____

Please check one of the following:

☐ I certify that my business applying for coverage with UnitedHealthcare is not part of a controlled group (commonly owned or affiliates) as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. (Single business that has no common ownership/affiliates)

Or

☐ I certify that my business(es) applying for coverage with UnitedHealthcare (1) is eligible to file a consolidated federal tax return or (2) meets the IRS test for being a controlled group as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. I further certify there are no other affiliated entities, other than the ones listed below, who are part of the controlled group that includes my business.

	Business Name :	Federal Tax ID # :	# of Eligible* :	On This Policy :
1.				Yes / No
2.				Yes / No
3.				Yes / No
4.				Yes / No
5.				Yes / No
6.				Yes / No

The undersigned certifies that the foregoing information is true, correct and complete, and fully understands that any false statements or failure to provide all available information may constitute the basis for rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.		
Name (please print) & Title:	Signature:	Date: