CoPower *SELECT*™

CoPower Administration and Plan Selection Form UnitedHealthcare

This form is to be completed by groups who wish to enroll in United Healthcare's ancillary offerings through CoPower.

Group Information - CoPower communication is by electronic mail		
Company:		
Contact Name:	E-mail:	
If you wish to opt out of E-mail communication, check this box ☐ and provide mailing address below.		
Street Address:		
City:	State:	Zip:
HR360 Enrollment *(Free Online HR Support)*: ☐ Yes ☐ No		

UHC Dental (2-100)

Dual Choice *(available to groups 10+ eligible)* ☐ Yes ☐ No

Choice of an Employer Sponsored HMO plan and PPO plan or PPO plan and PPO plan (limited to specific plans).
If yes, check two boxes in the plan selection below. Dual option for voluntary is not available.

HMO Plans	**Employer Sponsored PPO**	**Voluntary PPO**
☐ Classic D250h	☐ Classic 2-4 1000 - 1P651	☐ Classic 2-4 1000 - 1P650
☐ Classic D251h (Voluntary)	☐ Classic 2-4 1500 - 1P653	☐ Classic 2-4 1500 - 1P652
☐ Elite D125h	☐ Classic 1000 - 1X655 *(5+ EE)*	☐ Classic 1000 - 1X654 *(5+ EE)*
☐ Elite D126h (Voluntary)	☐ Classic 1000 w/ Ortho – 1X679 *(5+ EE)*	☐ Classic 1000 w/ Ortho – 1X685 *(5+ EE)*
	☐ Classic 1500-1X657 *(5+ EE)*	☐ Classic 1500 - 1X656 *(5+ EE)*
	☐ Classic 1500 w/ Ortho – 1X680 *(5+ EE)*	☐ Classic 1500 w/ Ortho – 1X686 *(5+ EE)*
	☐ Preferred 1250 - 1X659 *(5+ EE)*	☐ Preferred 1250 - 1X658 *(5+ EE)*
	☐ Preferred 1500 w/ Ortho - 1X661 *(5+ EE)*	☐ Preferred 1500 w/ Ortho - 1X660 *(5+ EE)*
	☐ Elite 2000 w/ Ortho - 1X663 *(5+ EE)*	☐ Elite 2000 w/ Ortho - 1X662 *(5+ EE)*

UHC Vision (2-100)

☐ Classic VL363	☐ Preferred V1020	☐ Elite VH001
☐ Classic V1043 (Voluntary)	☐ Preferred V1008 (Voluntary)	☐ Elite VH005 (Voluntary)

UHC Life (2-100)

Basic Life and AD&D:	**Dependent Life Amount**:	**Supplemental Life and AD&D** (10+ life groups only)
Prior Carrier: ☐ None	Prior Carrier: ☐ None	Prior Carrier: ☐ None
Cancel Date:	Cancel Date:	Cancel Date:
Total # of Enrolling Employees: _____	Total # of Enrolling Dependents: _____	Total # of Enrolling Employees: _____
6-19 Eligible Employees ☐ $20K ☐ $25K ☐ $50K **20-50 Eligible Employees** ☐ $25K ☐ $50K ☐ $75K ☐ $100K **51-100 Eligible Employees** ☐ $25K ☐ $50K ☐ $75K ☐ $100K ☐ $125K ☐ $150K ☐ $175K	Amounts tied to chosen Basic Life amounts **6-19 Eligible Employees** ☐ $20K (Spouse $2,000/Child* $1,000) ☐ $25K (Spouse $4,000/Child* $2,000) ☐ $50K (Spouse $7,500/Child* $3,750) **20-50 Eligible Employees** ☐ $25K (Spouse $2,000/Child* $1,000) ☐ $50K (Spouse $4,000/Child* $2,000) ☐ $75K-$100K (Spouse $7,500/Child* $3,750) **51-100 Eligible Employees** ☐ $25K (Spouse $2,000/Child* $1,000) ☐ $50K (Spouse $4,000/Child* $2,000) ☐ $75K-$175K (Spouse $7,500/Child* $3,750) **Child (minimum 14 days old)*	Enrolling in Supplemental Life?: ☐ Yes ☐ No *If yes, *Enrolling Employees need to fill out Life Insurance Enrollment/Change Form* Amounts Available for Employees (10-100 EE) 1x or 2x Salary or 10K increments up to $100K (20 - 50 EE) 1x or 2x Salary or 10K increments up to $200K (51-100 EE) 1x or 2x Salary or 10K increments up to $300K Amounts Available for Dependents: Spouse: ☐ $10K ☐ $20K Child: ☐ $5K ☐ $10K

Payment/Invoice - CoPower communication is by electronic mail

Invoices If you wish to opt out of E-mail invoices, check this box ☐

Contact Name _____ Email address _____

The above information will be used to authenticate access to the invoice. You must notify CoPower if this contact or e-mail address changes.

Initial Payment Do you wish to have your initial payment debited from your company account?

☐ Yes Please complete the bank information below, enter the premium amount and attach a copy of a voided check.

☐ No Please submit a company check made payable to CoPower.

Ongoing Payment Do you wish to have your monthly invoice amount automatically debited from your company account?

☐ Yes Please complete the bank information below and attach a copy of a voided check. ***(****Allow up to one billing cycle to process your request. You must continue to submit your payment until your invoice indicates that the amount due will be debited from your account.)*

☐ No

Bank Account Information *(must be a Checking Account)*

Account Holder's Name (if different from above): _____

Name of Bank: _____

Bank Address: _____

Bank Routing Number: _____

Account Number: _____

Premium Amount – Number (e.g. $50): $ _____

Premium Amount – Written (e.g. fifty dollars) _____ dollars

I hereby authorize CoPower to initiate debits from the account identified above. I understand it remains in effect until I give written notice to CoPower, which I must do by the 25th of the month prior to the month coverage. If I want to change the banking information that CoPower debits, I will submit a new Direct Debit Authorization form by the 25th of the month prior to the month of coverage. In the event a debit is made to my account in error, I authorize CoPower to make a correcting entry to my account. CoPower will notify me of payments returned for insufficient funds or close accounts, and repayment instructions.

Employer Signature

My Signature on this document certifies that all of the information contained in this application is true and correct to the best of my knowledge. I confirm that all enrollees are eligible employees, COBRA participants, and/or their dependents. In addition, my group complies with all the rules and regulations as set forth by the applicable carrier(s).

Signature of Company Officer:	Date:
Name (print):	Title (print):

(For CoPower Internal Use Only)

CALIFORNIA

Employer Application for Small Business

UnitedHealthcare®

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. Complete and submit the Product and Benefit Selection Form.
3. Submit the most recent billing statement listing those currently insured/covered and current status.
4. Submit most recent wage and tax information.
5. Include a deposit check for any required premiums.
6. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

UnitedHealthcare Insurance Company
UnitedHealthcare of California

General Information

				Effective Date
Group's Legal Name				Tax ID
DBA, if applicable				
Group name to appear on ID card (maximum 30 characters and spaces)				
Address				Start Date of Business
City	State	Zip Code	Telephone	Fax
Billing Contact / Title		Telephone	Email Address	
Billing Address (If different)				
Executive Contact / Title		Telephone	Email Address	
Administrative / Service Contact / Title		Telephone	Email Address	

Organization Type: ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Non-Profit ☐ Sole Proprietor ☐ Other Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No	Nature of Business	Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No	# of Locations	Address(es) (Use additional sheet of paper if necessary)

*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.

#of hours per week to be eligible	Classes Excluded (if applicable): ☐ None ☐ Union ☐ Hourly (# of hours_____) ☐ Non-Management	Waiting Period for New Hires (Not to exceed 90 calendar days) ☐ 1st of the month following Date of Hire ☐ 1st of the month following _____ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ _____ [months] [days] of employment following Date of Hire	Waiting Period for Rehire ☐ 1st month following _____ [months] _____ [days]	Waiting Period Waived for Initial Enrollees ☐ Yes ☐ No

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

Have Workers' Comp ☐ Yes ☐ No	Workers' Comp Carrier Name or Reason if no coverage	Names of Owners/Partners not covered by Workers' Comp

Names of Persons currently on COBRA/Continuation:			
Name	☐ COBRA ☐ Cal-COBRA ☐ COBRA-AB1401 ☐ Extended/Disabled COBRA	COBRA Qualifying Event	COBRA Date of Qualifying Event
Name	☐ COBRA ☐ Cal-COBRA ☐ COBRA-AB1401 ☐ Extended/Disabled COBRA	COBRA Qualifying Event	COBRA Date of Qualifying Event

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Coverage provided by "UnitedHealthcare and Affiliates":
Check appropriate box(s) for coverage(s) selected:
Medical ☐ UnitedHealthcare Insurance Company (Insurance Products: Select, Select Plus, Non-Differential PPO)
Medical ☐ UnitedHealthcare of California (HMO)
Dental ☐ UnitedHealthcare Insurance Company
Vision ☐ UnitedHealthcare Insurance Company
Administrative services provided by United Healthcare Services, Inc., OptumRx, Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

General Information (continued)

Has the Group been insured/covered by UnitedHealthcare in the last 12 months? ☐ Yes ☐ No If yes, date coverage terminated

Name of Current Medical Carrier	Begin Date	Name of Current Dental Carrier	Begin Date
☐ None	End Date	☐ None	End Date

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)
☐ Three months (following the last day worked for the minimum hours required to be eligible)
☐ Six 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**

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 three 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 six 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 described in the Certificate of Coverage.

Participation

		# Applying for:		# Waiving for:		Contribution	Employer %	Employer % for Dep
# Full-Time (30 hours per week over the course of a month) Eligible Employees Enrolling in CA		Medical		Medical		Medical		
# Part-Time (20-29 Hours) Eligible Employees Enrolling in CA		Dental		Dental		Dental		
# Full-Time (30+ Hours) Eligible Employees Enrolling Outside of CA		Vision		Vision		Vision		
# Part-Time (20-29 Hours) Eligible Employees enrolling Outside of CA		Other		Other		Other		
# Employees in Waiting Period (Not exceed 90 calendar days)								
Total # Employees Waiving								
# Ineligible Employees (other than noted above)								
Total # Employees								

Questions Regarding Group Size

☐ COBRA ☐ State Continuation (e.g., Cal-COBRA)	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
☐ Medicare Primary ☐ Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact their legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.
Enter the Prior Calendar Year Average Total Number of 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).

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Questions Regarding Group Size (continued)

☐ 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)?
☐ 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	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) ☐ Governmental ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Church ☐ Taft Hartley Union ☐ Employer Association
☐ 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.

Important Information

I understand that the *Evidence of Coverage, Certificate of Coverage* or *Summary Plan Description*, and other documents, notices and communications regarding the coverage indicated on this application, herein referred to as "Disclosure Materials," will be transmitted electronically to the Group/Company.

I acknowledge and affirmatively agree, on behalf of the Group/Company, to provide the applicable Disclosure Materials provided by UnitedHealthcare and Affiliates that contain information regarding benefits, services, exclusions, limitations and terms of the enrollee's health care coverage in electronic form and/or hard copy to enrolled members in accordance with California and federal laws, so as to afford the enrollee full and fair disclosure.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. **I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes. If UnitedHealthcare can demonstrate you committed an act or practice that constituted fraud or an intentional misrepresentation of a material fact, it may result in rescission of the group/company policy/agreement, termination of coverage, or increase in premiums retroactive to the original effective date of the agreement/policy. UnitedHealthcare will issue a written notice via regular certified mail at least 30 days prior to the effective date of the rescission explaining the basis for the decision of rescission and your appeal rights. After 24 months following the issuance of the agreement/policy, UnitedHealthcare will not rescind the agreement/policy for any reason, and will not cancel the agreement/policy, limit any of the provisions of the agreement/policy, or increase premiums on the agreement/policy due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.** Group/Company will receive any notices for failure to pay and/or termination in writing. In accordance with the Group Subscriber Agreement/Policy, Group is delegated to provide notice of termination to each subscriber/insured person at the subscriber's/insured person's current address. For nonpayment of premiums, UnitedHealthcare and Affiliates will send a notice of termination with appeal rights directly to the member.

The falsity of any statement in the application for any Policy/Group Subscriber Agreement shall not bar the right to recovery under the Policy/Group Subscriber Agreement unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer/health care service plan.

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 pay "base commissions" based on factors such as product type, amount of premium, group 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/agreements (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/agreement, please contact your producer.

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BINDING ARBITRATION

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN GROUP/COMPANY, MEMBERS AND ENROLLEES (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION BY A SINGLE NEUTRAL ARBITRATOR IN ACCORDANCE WITH THE COMMERCIAL RULES OF THE AMERICAN ARBITRATION ASSOCIATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO A COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE §1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. § 1 ET SEQ. IF A CLAIM FOR MEDICAL MALPRACTICE SEEKS TOTAL DAMAGES OF $50,000 OR LESS, THE CLAIM OR DISPUTE SHALL BE DECIDED BY A SINGLE NEUTRAL ARBITRATOR WHO SHALL HAVE NO JURISDICTION TO AWARD MORE THAN $50,000. IF THE PARTIES ARE UNABLE TO AGREE TO THE SELECTION OF A SINGLE ARBITRATOR, THE METHOD FOR THE APPOINTMENT OF THE ARBITRATOR IN CALIFORNIA CODE OF CIVIL PROCEDURE SECTION 1281.6 SHALL BE UTILIZED.

Authorized Signer for Group (Name Required)	Title (Required)
Signature (Required)	Date (Required)

Producer Information (if applicable)

Writing Producer Name				Writing Producer SSN		
Holds Current Appointment with ☐ UnitedHealthcare	Payee CA License #	Payee CA License Expiration Date		Writing Agent's License #	Writing Agent's License Expiration Date	
All Payments to		Payee Code	CRID Code	Tax ID#	If more than one Producer*, Split _____%	
Street Address		City			State	ZIP Code
Producer Phone #	Producer Fax Number			Producer Email Address		

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, the effect of misrepresentations, and termination provisions were discussed.

Please Check One of the Following (Required):

☐ I attest that I assisted the applicant in submitting this application to UnitedHealthcare. To the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that, to the best of my knowledge, the applicant understood the explanation.

☐ I attest that I did not advise or assist the applicant whatsoever in providing answers or responses to any of the questions contained in the application.

IMPORTANT NOTICE: If you willfully state as true any material fact you know to be false, you are subject to a civil penalty of up to ten thousand ($10,000) pursuant to California Insurance Code Section 10119.3 and California Health and Safety Code Section 1389.8.

Producer Signature	Date

***If more than one Producer, provide the second Producer's information on an additional sheet of paper.**

General Agent Information (if applicable)

General Agent LISI, Inc.	General Agent Tax ID# 94-2757978	Phone # (650) 348-4131	Franchise Code	
Street Address 1600 W. Hillsdale Blvd.	City San Mateo		State CA	ZIP Code 94402
Contact Name Mona Mehta	Email Address mmehta@lisibroker.com			

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