



Level Funded Application for Excess Loss Insurance

A Stock Company: P.O. Box 31394, Salt Lake City, UT 84131-0373 • 1-877-797-8812

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by UnitedHealthcare Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant:		
Address (street, city, state and ZIP):		
Key Contact:	Telephone:	Tax ID:
Applicant is a <input type="checkbox"/> Corporation <input type="checkbox"/> Labor Union <input type="checkbox"/> Partnership <input type="checkbox"/> Association <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other: _____		
Nature of Business of the Group to be Insured:		Requested Effective Date:
Total Number of Eligible Persons:	Total Number of Plan Participants:	Are Retirees Covered? <input checked="" type="checkbox"/> No
Affiliates or Subsidiaries: _____ _____	Addresses of Affiliates or Subsidiaries: _____ _____	

Full Name of Administrator: United HealthCare Services, Inc.

Address: P.O. Box 31394, Salt Lake City, UT 84131-0373

Key Contact: Susan Steele

Telephone: 1-877-797-8812

Agent or Broker:
Tax ID/NPN No.:
Address:

SPECIFIC EXCESS LOSS INSURANCE: ☒ Yes

Incurred Benefit Period: From _____ through _____
Paid Benefit Period: From _____ through _____
Specific Deductible per Covered Person: <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> other (100+ only) _____
Specific Percentage Reimbursable: 100%
Maximum Specific Benefit per Covered Person: Unlimited
Covered Expenses Under Specific Excess Loss: Medical, Stand-Alone Prescription Drug Program

AGGREGATE EXCESS LOSS INSURANCE: ☒ Yes

Incurred Benefit Period: From _____ through _____
Paid Benefit Period: From _____ through _____
Covered Expenses under Aggregate Excess Loss Coverage: <input checked="" type="checkbox"/> Medical, <input checked="" type="checkbox"/> Stand-Alone Prescription Drug Program, <input type="checkbox"/> Dental, <input type="checkbox"/> Vision
Aggregate Percentage Reimbursable: 100%
Maximum Aggregate Benefit: Unlimited
Minimum Annual Aggregate Deductible: N/A
Aggregate Accommodation Endorsement included.

It is understood and agreed by the undersigned that:

- a. The statements, declarations, and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Plan Sponsor should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
- b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 30 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 30 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.
- c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
- d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.
- e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____ Title: _____

Date: _____

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Alabama, Arkansas, Louisiana, New Mexico, and Rhode Island:

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.

For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for 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 application.

For applicants in 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 applicants in Kentucky, New Mexico, Ohio, and 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 applicants in Maine and Tennessee:

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 applicants in 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 applicants in 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 applicants in Oklahoma:

A 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 applicants in 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 applicants in all other states:

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.

Person must reside within the United States. An employee residing in Hawaii is not an eligible person.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

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