Employer Information Form

UnitedHealthcare®

SECTION A		
Employer (legal) **Name & DBAs:**	**Customer/Group#:**	**Federal Employer Identification Number (EIN):**
Nature of Business (product sold/service provided):	**Telephone #:**	**Email Address:**
Physical Address:	**Billing Address** (if different):	

SECTION B				
Type of Business Organization for Federal Tax Purposes (check one):	☐Sole Proprietor	☐C-Corporation	☐S-Corporation	☐ LLC
	☐Partnership/LLP	☐Non-Profit	☐Farm	

SECTION C	
1. Is the group maintaining the minimum contribution requirement defined in your Group Policy?	☐Yes ☐No
2. Do you offer coverage to any contracted 1099 workers? *If yes, please submit the most recent 1099-MISC forms for all of your 1099 workers.	☐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 full-time eligible employees other than the owner and owner's spouse?	☐Yes ☐No
5. Please print, sign and date the form below. **Once this page of the Employer Information Form is completed please refer to Page 2 of this document and provide tax documentation and status codes for all employees and owners of the business. Please refer to Section E and F for acceptable documentation and assistance.**	

SECTION D

The undersigned employer, or duly authorized representative, certifies that the foregoing information is true, correct and complete to the best of his/her knowledge or belief, and fully understands that any false statements or failure to provide all available information may constitute the basis for termination of coverage at the option of the insurer and/or the group policy's administrative representative.

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

SECTION E

☐ **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. If you do not file a quarterly wage and tax report, please provide the documentation shown below.**

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.

Does the business have any owners or employees not listed on the quarterly wage and tax statement?

☐ No
☐ Yes - please provide the additional documentation below.
☐ N/A - I do not file a quarterly wage and tax report - please provide the documentation below.

Sole Proprietor	IRS 1040 Schedule C or Schedule F (Farm)
S-Corporation	IRS Schedule K1 for each owner, totaling 100% (Form 1120S Corporation Filing)
C-Corporation	IRS Form 1120 Corporation Filing - Page 1 and 2; Schedule G, K#5 or 1125-E
Partnership/LLP	IRS Schedule K-1 for each partner, totaling 100% (Form 1065)
LLC	IRS 1040 Schedule C or Schedule K-1
Non-Profit	Most recent Federal Form 941 and most recent 2-week payroll identifying all employees and earnings.
Contracted Employee	Form 1099-MISC for all contracted employees (if coverage is offered to 1099 contracted employees)
Cobra or State Continuation	Indicate eligibility date for Cobra or State Continuation/Qualifying Event Date. Please provide the last quarterly wage and tax report they appeared on.
New Hire	Most recent 2-week payroll report identifying all employees and earnings.
Spouse of Owner	Most recent W2
If group is on Extension	Form 4868 or Form 7004 and the previous year's tax documentation.

SECTION F

☐ Next to each employee listed on the state quarterly wage and tax report, ownership documentation, 1099-MISC forms etc., indicate the state of residency and date of hire or termination. Also, **directly on the tax documentation,** include the appropriate status code listed below for each employee.

A	**Actively Enrolled Plan Participant**	PT	**Part Time Employee** Includes temporary and seasonal employees.
CO	**COBRA/Continuation** Indicate eligibility date and whether coverage is provided by a prior employer or by your company. If by this employer please provide the last quarterly report they appeared on.	SP	**Spouse's Employer Sponsored Plan**
GR	**Group Coverage** Indicate if the coverage is sponsored by this employer or through another employer.	TR	**Terminated Employee** Indicate date of termination.
ID	**Individual Coverage**	TC	**Tricare**
LA	**Leave of Absence**	VA	**Veterans Administration Coverage**
MC	**Medicare**	UC	**Union Coverage**
MD	**Medicaid**	WP	**Waiting Period** Indicate date of hire and date employee will be eligible for coverage.
PC	**Parental Coverage**	DE	**Declined (i.e. due to cost or does not want)** Only use this code if the employee is full time with no other coverage or waiver reason.

RISK MANAGEMENT CONTACT INFORMATION

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

***** Include your group number in all correspondence *****