UnitedHealthcare
Risk Management MN017-E700
9700 Health Care Lane
Minnetonka, MN 55343-4527

April 20, 2018

DPS$$$PKG
GROUP NAME
Attn: CONTACT NAME
1234 STREET RD
CITY ST 00000-0000

RE: ELIGIBILITY VERIFICATION – YOUR RESPONSE IS REQUIRED
Group Name:
Group Number: 0U0000
Renewal Date: 8/1/2018

Dear FIRST LAST,

We appreciate your continued business as a valued UnitedHealthcare policyholder. One of the requirements associated with your group insurance contract is that your group must cover a set percentage of all eligible employees at the time when your plan year renews in order for your group to have the option to continue your coverage. Therefore, we are writing today to request updated tax and census information from your group in order to confirm that your group meets our participation and eligibility requirements as allowed by law.

Here is what you need to do as soon as possible after receiving this letter:

- Complete the attached Employer Information Form.
- Provide your two most recent state quarterly wage and tax reports.
- Indicate the status of each employee on the tax documentation form(s) you submit.
- Provide copies of health insurance ID cards for any employees waiving medical coverage.
- Have an officer of your company sign the attached Common Ownership form.
- **Return the completed forms by mail, fax or e-mail to:**

Mail: UnitedHealthcare
Attn: Risk Management MN017-E700
9700 Health Care Lane
Minnetonka, MN 55343-4527
Fax: (877) 232-7902
Email: Risk.Management@uhc.com

If you do not submit all of the required information, we will be forced to non-renew (cancel) your group coverage as of 8/1/2018. Take Action soon! It takes time to review your documents and submitting documentation too close to your renewal date may result in unavoidable termination due to the timing of the verification process. Please allow at least five (5) business days to process your information. Upon completing the verification you will receive a status letter. Note that you may receive renewal information separately while you complete this request. However, if we cannot confirm your participation requirements, that renewal information is not valid.

All forms and tax documentation submitted are considered confidential and proprietary and will be used only in the Risk Management Department for verification of participation and eligibility requirements.

Your assistance is vital to the continuation of your UnitedHealthcare insurance, and we appreciate your cooperation. If you have questions regarding this request, **please visit our website at www.uhctools.com/rm**, or contact us via email at Risk.Management@uhc.com or by phone at 877-504-1179. Please include your name, group number, and telephone number with any messages.

Risk Management

CC: BROKER NAME

Enclosures (Employer Information Form, Common Ownership Cert)

Employer Information Form

UnitedHealthcare®

SECTION A

Employer (legal) **Name & DBAs:**	**Customer/Group#:** **0U0000**	**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 <u>two</u> most recent quarterly wage and tax statements 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. <u>Copies of health insurance ID cards are required for any employee waiving medical coverage</u>. 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)** <u>Only</u> 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 x35584

***** Include your group number in all correspondence - 0U0000 *****

Common Ownership Certification

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.

Customer Name: ______________________________

Group Number (if renewal): 0U0000

Primary Business Location: ______________________________

	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

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.

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 under common control. I further certify there are no other affiliated entities, other than the ones listed above, who are part of the controlled group that includes my business.

I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I agree to notify UnitedHealthcare in the event of a change in any of the information that is the subject of this certification. I understand that any misrepresentation or fraudulent statement may result in 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: