UnitedHealthcare
A UnitedHealth Group Company

AFFIDAVIT OF PREVIOUS HEALTH BENEFIT COVERAGE

The following must be completed and returned to UnitedHealthcare before your enrollment may be considered. **Please have this form completed and signed by the owner or an appropriate officer of the company.**

☐Yes ☐ No 1. Have you sought small group coverage from any carrier during the twelve months prior to application for UnitedHealthcare coverage?

☐Yes ☐ No 2. Have you purchased health benefit coverage that is insured through a health benefit plan other than a small group plan during the twelve months prior to application for UnitedHealthcare coverage?

☐Yes ☐ No 3. Have you purchased health benefit coverage that is self-funded but is not a small group self-funded plan during the 12 months prior to application for UnitedHealthcare coverage?

☐Yes ☐ No 4. Has your small group insurance been discontinued by any carrier because of nonpayment of premiums or fraud?

☐Yes ☐ No 5. Have you sponsored a group policy during the twelve months prior to application and failed to report it to UnitedHealthcare below?

☐Yes ☐ No 6. If you are applying as a business group of one, have you previously qualified as a business group of one prior to application with UnitedHealthcare?

☐Yes ☐ No 7. Have you sponsored a health plan for your employees within the last twelve months prior to application for UnitedHealthcare coverage?

☐Yes ☐ No 8. Have you participated in an employee leasing company (PEO) but are no longer part of the employee-leasing contract?

☐Yes ☐ No 9. Are you currently using an employee leasing company that does not offer a health benefit plan or because of action by an insurer has ceased offering a benefit plan at certain locations?

☐Yes ☐ No 10. Have you purchased small group health benefit coverage and discontinued health benefit coverage as a small employer prior to Jan 1, 2004?

If you have sponsored a health benefit plan during the past twelve months, please attach a copy of your most recent bill.

I, the undersigned, attest that the answers to the questions in this form are correct. I acknowledge that failure to report such previous group coverage may result in the application of a premium adjustment for health status of up to thirty-five percent above the modified community rate for a small employer carrier.

______________________	______________________	______________________
Business Name	Employer Tax ID Number	Name of Owner/Officer
______________________	______________________	______________________
Title of Owner/Officer	Owner/Officer Signature	Date