

SBS Group Enrollment Checklist

We've created this checklist to make doing business with SBS convenient. All forms listed below are available on www.uhcspecialtybenefits.com/SBS. All fields on the following group questionnaire are required, unless otherwise noted.

TO ENROLL A NEW GROUP INTO A PLAN, THE FOLLOWING GUIDELINES MUST BE MET:

- Effective dates of coverage can only be the 1st of each month.
- For Contributory plans the employer must contribute at least 50% towards the employee's premium; Voluntary plans – less than 50%
- Contributory groups must have at least 75% of the active eligible employees enrolled, excluding those waived with spousal coverage. Voluntary must have at least 2 employees enrolled.

PLEASE SELECT ONE PLAN OPTION:

SBS **Classic** Plan Option

- Contributory
Voluntary

*Buy up options are not available with the **Classic** plan.*

SBS **Preferred** Plan Option

- Contributory
Voluntary

Buy up options:

- Orthodontia Yes No
\$1500 Maximum: Yes No
Waive Waiting Periods: Yes No

Waive Waiting Period available only with Contributory plans.

SBS **Elite** Specialty Option

- Contributory
Voluntary

Buy up options:

- Orthodontia: Yes No
\$1500 Maximum Yes No
Waive Waiting Periods" Yes No

Waive Waiting Period available only with Contributory plans.

TO ENROLL A NEW GROUP INTO A PLAN, THE FOLLOWING ITEMS MUST BE SUBMITTED:

- A completed Group Enrollment Checklist.
- A binder check equal to one month's premium made payable to Specialty Benefit Solutions.
- A copy of the quote or installation sheet that prints from the online enrollment.
- A Wage and Tax Statement or current payroll information or a recent prior carrier bill (medical or ancillary). See Underwriting Guidelines for details.
- If the group had prior dental coverage through another carrier, a copy of the group's current summary of benefits and recent bills or renewal notice demonstrating 12 months of coverage (6 months in New York).

Group Name: _____

Requested Effective Date: _____

Primary Contact: _____

Group Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-mail: _____

Billing Address: (if different from above)

City: _____ State: _____ Zip Code: _____

Type of Business:

Corporation Partnership Proprietorship Other

SIC Code: _____ Tax ID: _____

Subject to ERISA? Yes No

Full Legal Name of Employer: _____

Has your company ever filed for or is it in the process of filing for bankruptcy? Yes No

PARTICIPATION

Total number of employees on payroll: _____

Total number of full-time eligible employees: _____

Total number of enrolling employees:

Employee Only: _____

Employee+Spouse: _____

Employee+Child: _____

Employee+Family: _____

Total number of waivers: _____

Does your company have UnitedHealthcare medical coverage?

If yes, group ID # _____

Did your company have prior dental coverage?

If yes, dates of coverage: _____ Carrier: _____

Multi Site:

Locations: _____

Number of COBRA participants in total group: _____

Number of retirees in total group: _____

EMPLOYER CONTRIBUTION _____ %

BROKER 1 INFORMATION

Brokerage: _____

Broker Name: _____

Broker#: _____

FTIN/SS#: _____

License#: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

E-mail: _____

Broker Signature: _____ Date: _____

Commission Percentage: _____

Commission Checks Payable To: _____

Payee / Broker / Agency #: _____

BROKER 2 INFORMATION

Brokerage: _____

Broker Name: _____

Broker#: _____

FTIN/SS#: _____

License#: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

E-mail: _____

Broker Signature: _____ Date: _____

Commission Percentage: _____

Commission Checks Payable To: _____

Payee / Broker / Agency #: _____

GENERAL AGENT INFORMATION

GA Name: _____

GA#: _____

FTIN/SS#: _____

License#: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

E-mail: _____

GA Signature: _____ Date: _____

Commission Checks Payable To: _____

Payee / Broker / Agency #: _____

SALES REPRESENTATIVE INFORMATION

UHC Sales Representative Name: _____

E-Mail: _____

UHC Specialty Benefits Representative Name: _____

E-Mail: _____

SUBMISSIONS SHOULD BE MAILED TO:

HealthInsight (formerly HNA/Triveris)
Attn: Specialty Benefit Solutions
745 Hope Road, Suite 200
Tinton Falls, NJ 07724

Or EMAILED TO:

SBS@HealthInsight.com