UHA HEALTH INSURANCE

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Print Form

EMPLOYER APPLICATION & CERTIFICATION FORM
(Groups with 50 or Fewer Employees)

Please complete this form. See reverse for instructions for submission.

Legal Name of Business: _____ DBA if applicable: _____

Type of Business/Industry _____

Street Address: _____

Mailing Address: _____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

Name and Title of Group Administrator: _____

Name of Owner/Business President: _____

Federal Tax ID #: (**Required**) _____ Dept. of Labor (DOL) #: (**Required**) _____

How did you hear about UHA? _____

Was your business ever covered by UHA Insurance before: Yes ☐ No ☐

If your business had UHA previously, please indicate the business name and policy number: _____

Broker/Consultant Name & Firm: _____

Do you intend to offer **UHA** health coverage to employees who reside outside of the state of Hawaii? Yes ☐ No ☐

Do you intend to also offer another health plan option (in addition to UHA) to your employees? Yes ☐ No ☐

Current Health Insurance Carrier(s) _____

Health Plan Name(s) _____ Renewal Date(s) _____

Current Rates: **Single:** _____ **Two Party:** _____ **Family:** _____

The above rates include: ☐ Medical ☐ Drug ☐ Vision ☐ Dental ☐ Other _____

Number of Eligible Employees: _____ Number of Employees Applying for Coverage: _____ Number of Total Employees*: _____

* (All employees working for business entity, including but not limited to those that waive coverage, employed part time or those that reside outside the state of Hawaii.)

Does your business qualify for COBRA coverage? (Must have 20 or more employees) Yes ☐ No ☐

ELIGIBILITY CERTIFICATION

This is to certify that the named employees for whom enrollment/application forms are submitted are bona fide employees of the above-named business. UHA may terminate coverage for any ineligible enrollee(s) upon confirmation of ineligibility. If enrollment is found to be based on fraud or intentional misrepresentation of a material fact by the employer, coverage for the Member Group and/or the enrollee(s) may be terminated by UHA. In the event of termination, we agree that any benefit payments made by UHA on behalf of the ineligible enrollee(s) must be returned in full to UHA by the ineligible enrollee(s) and/or employer. UHA shall return all premiums paid by the employer with respect to the ineligible enrollee(s) upon termination of coverage and reimbursement of payments made by UHA. Furthermore, it is understood and agreed that if such falsified or misrepresented information regarding employment must be proved by legal or investigative means, then the costs for such efforts will be reimbursed by the ineligible enrollee(s) and/or employer. The proof of employment rests on the employer. Each employer will adhere to the UHA Group Administration Guidelines. Failure to comply with the Guidelines which amounts to fraud or intentional misrepresentation of a material fact by the employer may result in termination of coverage of the Member Group and/or any affected enrollee(s).

_____ _____

Print Name of Group Administrator (Required) Signature Date

_____ _____

Print Name of Broker/Consultant, if Applicable Signature Date

NOTICE TO PROSPECTIVE EMPLOYER GROUP

UHA provides health insurance coverage to qualified employer groups doing business in the State of Hawaii. We offer medical, prescription drug, vision, and dental insurance. Because UHA offers only employer group health insurance, we require that all prospective groups have a valid Department of Labor number and at least one covered regular employee under our plan.

A Regular Employee means:

1) A person who is employed for at least 20 hours per week, but does not include a person employed in seasonal employment; and
2) A person who performs some services in Hawaii and the place from which such service is directed or controlled is in Hawaii, or if the service is not directed or controlled in Hawaii, the individual's residence is in Hawaii.

UHA will deny medical benefits to any member it determines is not a Regular Employee. UHA reserves the right to cancel an employer group's policy if it determines that the employer has committed fraud or made an intentional misrepresentation of material fact in enrolling persons who are not bona fide Regular Employees.

In order to provide your company with a rate proposal, UHA requires that a **CENSUS FORM** and **EMPLOYER APPLICATION & CERTIFICATION FORM** be completed and returned to UHA. All required forms should be sent to UHA by fax, mail or email. If you have any questions or require assistance in completing these forms, feel free to contact us below.

FOR BROKERS
Client Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
Phone: 808.532.4000 ext. 358
Fax: 1.877.222.3198
Email: clientservices@uhahealth.com

FOR UHA DIRECT SALES
Sales Department
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
Phone: 808.532.4009
Fax: 1.866.577.3035
Email: sales@uhahealth.com

VISIT OUR WEBSITE AT: uhahealth.com

Once we have received the completed forms, UHA will generate a rate proposal for your company. An Account Executive or your Broker will then contact you with our proposed rates and answer any questions you may have.

Thank you for considering UHA for your health insurance needs.