700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4009
800.458.4600
F 866.577.3035
uhahealth.com

EMPLOYER APPLICATION & CERTIFICATION FORM

Please complete this form and review the important information and instructions on the reverse side. All fields are required unless indicated optional.

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 #: ______________________ Dept. of Labor (DOL) #: ______________________

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 offer UHA health coverage to dependents 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 Hawaii employees? Yes ☐ No ☐

Number of Eligible Employees	Number of Employees Applying for Coverage	Number of Total Payrolled Employees †	Employer Premium Contributions:	Single	Two Party	Family
________	________	________		________%	________%	________%

† All employees working for employer, including those that waive coverage, are employed part time, or reside outside Hawaii.

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

Is your company a subsidiary, affiliate, or under common control with another company as provided under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code? Yes ☐ No ☐

ELIGIBILITY CERTIFICATION

This is to certify that the named employees for whom a census form is submitted are bona fide employees of the above-named business. If this application is accepted by UHA, the employer will adhere to the UHA Underwriting Rules in the Standard Agreement for Group Health Plan. UHA may terminate coverage for any ineligible enrollee(s) upon confirmation of ineligibility and failure to comply with the UHA Underwriting Rules which amounts to fraud or intentional misrepresentation of a material fact may result in termination of coverage of the business and/or any affected enrollee(s) The proof of employment and eligibility rests on the employer. In the event of termination, the employer understands and agrees 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 and UHA shall return applicable premiums paid by the employer with respect to the ineligible enrollee(s). It is also 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.

______________________ ______________________

Print Name of Group Administrator — Signature — Date

______________________ ______________________

Print Name of Broker/Consultant, if Applicable — Signature — Date

RKM-0071-012021

Current Health Insurance Carrier ______________________________

Health Plan Name ______________________________ Effective Date ______________

Attach Separate Page For Rates If Needed	**Previous Rates**	**Current Rates**	**Renewal Rates**
Single			
EE + Spouse			
EE + Child(ren)			
Family			

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

Current Health Insurance Carrier ______________________________

Health Plan Name ______________________________ Effective Date ______________

Attach Separate Page For Rates If Needed	**Previous Rates**	**Current Rates**	**Renewal Rates**
Single			
EE + Spouse			
EE + Child(ren)			
Family			

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

Current Health Insurance Carrier ______________________________

Health Plan Name ______________________________ Effective Date ______________

Attach Separate Page For Rates If Needed	**Previous Rates**	**Current Rates**	**Renewal Rates**
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EE + Child(ren)			
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The above rates include: ☐ Medical ☐ Drug ☐ Vision ☐ Dental ☐ Other ______________

Current Health Insurance Carrier ______________________________

Health Plan Name ______________________________ Effective Date ______________

Attach Separate Page For Rates If Needed	**Previous Rates**	**Current Rates**	**Renewal Rates**
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EE + Child(ren)			
Family			

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

IMPORTANT INFORMATION

This is an application for coverage only. No contract for coverage exists until UHA has completed its review and communicated to the business applicant or the applicant's broker that a Standard Agreement for Group Health Plan will be issued.

UHA provides health insurance coverage only to qualified employers doing business in Hawaii. All employers may be subject to audit at UHA's discretion. Audits are done to ensure that employers and the individuals they enroll meet all UHA requirements and those set forth in the Hawaii Prepaid Healthcare Act (Hawaii Revised Statutes, Chapter 393) and its administrative rules. Among other requirements, employers must have and maintain a valid Department of Labor number, Unemployment Insurance, Worker's Compensation, Temporary Disability Insurance and maintain on payroll at least one eligible employee on a UHA plan.

INSTRUCTIONS

To provide your business with a rate proposal, UHA requires that a **CENSUS FORM** and **this EMPLOYER APPLICATION & CERTIFICATION FORM** be completed and returned to UHA. The 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
1.800.458.4600 ext. 358
Fax: 1.877.223.3198
Email: clientservices@uhahealth.com

FOR UHA DIRECT SALES
Sales Department
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
Phone: 808.532.4009
1.800.458.4600
Fax: 1.866.577.3035
Email: sales@uhahealth.com

VISIT OUR WEBSITE: uhahealth.com

Once we have received the completed forms, UHA will generate a rate proposal for your business. 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.