UHA HEALTH INSURANCE

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Honolulu, HI 96813.4100
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800.458.4600
F 866.577.3035
uhahealth.com

EMPLOYER APPLICATION & CERTIFICATION FORM

Please complete this form. All fields are required unless indicated optional. Also, you must read the Important Information and Instructions on the last page before you sign the Eligibility Certification below.

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 ☐

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

† 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 the Census Form and this Employer Application & Certification Form are accepted by UHA, the employer will adhere to the UHA Underwriting Rules in the Standard Agreement for Group Health Plan. Any ineligible enrollee(s) upon confirmation of ineligibility and failure to comply with the UHA Underwriting Rules, which amounts to fraud or intentional misrepresentation or concealment of a material fact may result in prospective or retroactive termination of coverage of the business and/or any affected enrollee(s), or a prospective or retroactive adjustment to premium rates. 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-0071-042822

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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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 + Spouse			
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. At that time, the Census Form and this Employer Application & Certification Form become part of the contract for UHA coverage.

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.

Coverage of eligible employees begins the first day of the month after employers provide health insurance coverage for eligible employees who have been in the employer's employ at least 20 hours per week for 4 consecutive weeks. Coverage may begin earlier, on the first day of the month following employment, if the employer has a written policy for earlier coverage, the employee has met or will meet an average of at least 20 hours per week, and the employer has discussed this written policy with their Account Executive upon submission of this Employer Application and Certification Form. UHA's audits may include a review of the employer's written policy.

UHA's offers employers UHA 600, UHA 3000, or the UHA One Plan. Please note that the UHA One Plan must be the only plan to provide medical care benefits offered to all eligible employees such that no other medical benefits plan is offered and UHA is the exclusive medical insurance carrier. If you wish to offer more than one medical benefits plan through another medical insurance carrier, then UHA One Plan may not be the best option for you.

If you have any questions regarding this Important Information please contact us as indicated below.

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.