

UNIVERSAL CARE GROUP APPLICATION & PARTICIPATION REQUEST

Used for groups of 2 or more employees



Universal Care®
Healthcare you can feel good about.

1600 E. Hill Street • Signal Hill, CA 90755
(800) 635-6668 ext. 4848
www.universalcare.com

Employer

The Employer Certifies the Following Information:

Employer's Name (as identified on the DE6, Schedule C or Business License)				Tax I.D. #	
Address		Contact Name		Contact Title	
City	State	Zip Code	Phone No.	Ext.	
			()		
Fax No.	E-mail Address		Living Wage Law Eligible		
()			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Legal Status (check appropriate box)		Nature of Business		SIC Code	
<input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Other (please specify):					

Subsidiaries and Affiliates to be covered

Bill Separately? Yes No

Name	No. of Employees	Name	No. of Employees
Address		Address	
City	State	Zip Code	City

Employer Eligibility

Eligible employees shall be active, full time employees who work at least hours per week.

Are all eligible employees subject to withholdings as appears on a W-2 form? Yes No

No. of Employees eligible for benefits	No. of Employees enrolling

If no, please explain:

Workers' Compensation

Current Worker's Compensation Carrier's Name



Be sure to sign and date application on back page.

Please list the name and title of any person who will be eligible as a subscriber under the Universal Care coverage who is not an employee for the purpose of worker's compensation law or similar legislation. Please refer to California Labor Code Sections 3351 through 3371, which define persons who are and are not covered under workers' compensation laws. Please refer to section 4151 for more detail regarding the Labor Code.

Name	Title	Exempt according to above requirements?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Waiting period for enrollment of future employees. (Eligibility date is always the first day of the month following the waiting period.)

Employer Contribution

Waiting Period for Enrollment

30 days 90 days
 60 days Other _____

Employee Premium

_____ %

Dependent Premium

_____ %

Requested Effective Date

Month | Day | Year

Actual effective date will be assigned by the Underwriting Department of Universal Care upon acceptance.

Effective Date

Month | Day | Year

This date will be assigned by the Underwriting Department of Universal Care upon acceptance.

Benefits Requested (Indicate plans and appropriate codes)

<input type="checkbox"/> Medical - Universal Care Network	<input type="checkbox"/> Rx Option	<input type="checkbox"/> Dental	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Medical - Champion Health Network	<input type="checkbox"/> POS	<input type="checkbox"/> Vision	<input type="checkbox"/> Other

COBRA

Do you want Universal Care to bill your COBRA subscribers direct? Yes No

By signing this application, applicant agrees to be bound by all provisions of the Universal Care Subscriber Agreement, upon acceptance by Universal Care. I have been advised not to terminate any existing coverage until receiving notice from Universal Care that coverage being applied for has been accepted. I confirm receipt of a *sample* Universal Care Subscriber Agreement with this application.

Dated at: _____ Month | Day | Year

Applicant's Authorized Signature **Title**

I hereby certify that: I am not aware of any information not disclosed in this application or employee application and enrollment forms by my client which may have a bearing on this risk. Agent's Initials _____

I hereby certify that: I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by the application is accepted. _____

I hereby certify that: I have advised my client of his/her rights under California Health and Safety Code Section 1357 and have provided him/her with all benefit options offered by Universal Care to small group employers. _____

Agent's Certification

Writing Agent's Name	Agent #	Tax I.D. Number
Agent Address	Telephone # ()	Fax # ()
Agent's Signature	E-Mail	Date Month Day Year

For company use only

Date Approved Month Day Year	Group #	UC Rep. #	Medical - UCN \$ _____
Effective Date Month Day Year	Reviewed By	Billing Code	Medical - CHN \$ _____
Date Declined Month Day Year	Adjusted Risk Factor	Entered By	POS \$ _____
			Dental \$ _____
			Chiropractic \$ _____
			Vision \$ _____
			Other \$ _____