Employer Information Form

UnitedHealthcare®
Oxford

SECTION A		
Employer (legal) **Name & DBAs:**	**Customer/Group#:**	**Federal Employer Identification Number (EIN):**
Nature of Business (product sold/service provided):	**Telephone #:**	**Email Address:**
Physical Address:	**Website (If applicable):**	

SECTION B	
Type of Business Organization for Federal Tax Purposes (check one):	☐ Sole Proprietor ☐ C-Corporation ☐ S-Corporation ☐ LLC ☐ Partnership/LLP ☐ Non-Profit ☐ Farm

SECTION C	
1. Is the group maintaining the minimum contribution requirement defined in your Group Policy?	☐ Yes ☐ No
2. Does the business have any owners or employees not listed on the quarterly wage and tax statement? *If yes, please provide a copy of the most recent ownership documents for all owners, confirming 100% ownership. See page 2 for common documents for each entity type. **If no, please indicate which employees are owners on the quarterly wage and tax statement	☐ Yes* ☐ No**
3. Is your group a Professional Employer Organization (PEO), Employee Leasing Company (ELC), or other such entity that is a co-employer, with your client(s), of client-site employees? *If yes, then by signing this form, you agree with the following certification: I hereby certify that my company is a PEO, ELC, or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. I understand that UnitedHealthcare will not cover the co-employees under this group policy.	☐ Yes* ☐ No
4. Does the business have any employees other than the owner and owner's spouse?	☐ Yes ☐ No

SECTION D
The undersigned certifies that the foregoing information is true, correct and complete, and fully understands that any false statements or failure to provide all available information may constitute the basis for rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Name (please print) **& Title** **Signature:** **Date:**

SECTION E

☐ **Please provide a copy of the most recent quarterly wage and tax statement filed with your state. This report is filed on a quarterly basis and lists all W2 employees for unemployment tax purposes. If you do not file a quarterly wage and tax report, please provide the documentation shown below.**

In order to validate full time employment and eligibility for coverage, do not black out earnings information. If you prefer, you may black out part of the Social Security Number, but leave at least the last 4 digits for identification verification.

Sole Proprietor	IRS 1040 Schedule C or Schedule F (Farm)
S-Corporation	IRS Schedule K-1 for each owner, totaling 100% (Form 1120S Corporation Filing)
C-Corporation	IRS Form 1120 Corporation Filing - Page 1 and 2; Schedule G, or Form 1125-E
Partnership/LLP	IRS Schedule K-1 for each partner, totaling 100% (Form 1065)
LLC	IRS 1040 Schedule C or Schedule K-1 totaling 100%
Non-Profit	Most recent Federal Form 941 and most recent 2-week payroll identifying all employees and earnings.
Contracted Employee	IRS Form 1099-MISC for all contracted employees (if coverage is offered to 1099 contracted employees)
New Hire	Most recent 2-week payroll report identifying all employees and earnings.
Spouse of Owner	Most recent 2-week payroll
If group is on Extension	IRS Form 4868 or Form 7004 and the previous year's tax documentation.

SECTION F

Next to each employee on the state quarterly wage and tax report, ownership documentation, 1099-MISC forms etc., **indicate the state of residency, average hours worked each week, and date of hire or termination.** Also, **directly on the tax documentation,** include the appropriate status code listed below for each employee, and verify if an Owner.

A	**Actively Enrolled Plan Participant**	PT	**Part Time Employee** Not working full-time hours and not eligible for coverage. Includes temporary and seasonal employees.
CO	**COBRA/Continuation** Indicate continuation start date and whether coverage is provided by a prior employer or by your company.	SP	**Spouse's Employer Sponsored Plan**
CH	**Champus**	TR	**Terminated Employee** Indicate date of termination.
GR	**Group Coverage** Indicate if the coverage is sponsored by this employer or through another employer.	TC	**Tricare**
ID	**Individual Coverage**	VA	**Veterans Administration Coverage**
LA	**Leave of Absence**	UC	**Union Coverage**
MC	**Medicare**	WP	**Waiting Period** Indicate date of hire and date employee will be eligible for coverage.
MD	**Medicaid**	DE	**Declined (i.e. due to cost or does not want)** Only use this code if the employee is full time with no other coverage or waiver reason.
PC	**Parental Coverage**		

RISK MANAGEMENT CONTACT INFORMATION

Website	www.uhctools.com/rm
Email Address	risk.management@uhc.com
Fax Number	1-877-232-7902
Toll-Free Phone Number	1-877-504-1179

***** Include your group number in all correspondence -*****