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 90806
(800) 635-6668 ext. 4848
www.universalcare.com

Employer

The Employer Certifies the Following Information:

Employer's Name	Tax I.D. #

Address	Contact Name	Contact Title

City	State	Zip Code	Phone No. Ext.
			( )

Fax No.	E-mail Address
( )	

Legal Status (check appropriate box)	Nature of Business	SIC Code
☐ Corporation ☐ Sole Proprietorship ☐ Partnership ☐ 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	State	Zip Code

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?
		☐ Yes ☐ No
		☐ Yes ☐ No

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

Waiting Period for Enrollment

☐ 30 days ☐ 90 days
☐ 60 days ☐ Other _____

Employer Contribution

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)

☐ Medical – Universal Care Network	☐ Rx Option	☐ Dental	☐ Chiropractic
☐ Medical – Champion Health Network	☐ POS	☐ Vision	☐ 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.

Dated at: _____ Month Day Year

Applicant's Authorized Signature | **Title**

Agent's Initials

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. _____

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. #**

Effective Date Month Day Year | **Reviewed By** | **Billing Code**

Date Declined Month Day Year | **Adjusted Risk Factor** ☐☐.☐☐ | **Entered By**

Medical – UCN	$ _____
Medical – CHN	$ _____
POS	$ _____
Dental	$ _____
Chiropractic	$ _____
Vision	$ _____
Other	$ _____