UnitedHealthcare
Risk Management MN012-N123
5901 Lincoln Drive
Edina, MN 55436-1611

UnitedHealthcare®

June 30, 2011

181MLETR2A0532201
STEVEN H SHORR
1027 W 11TH ST APT 3
SAN PEDRO, CA 90731-3558

RE: ELIGIBILITY VERIFICATION – YOUR RESPONSE IS REQUIRED
Group Name:
Group Number
Cancel Date: 10/1/2011

Dear

Our records show that your group has only one employee enrolled in the group health benefit plan. Unless you can show that your group meets the minimum participation guidelines in your Group Policy, all coverage under this plan will terminate on **10/1/2011**.

If you wish to be reconsidered for coverage, we must be able to verify that you meet the participation and eligibility requirements by the cancel date. To verify these requirements, please complete the attached Employer Information Form and provide your most recent supporting tax documentation. Return the completed forms by mail, fax, or email to:

Mail: UnitedHealthcare
Attn: Risk Management MN012-N123
5901 Lincoln Drive
Edina, MN 55436-1611
Fax: (877) 232-7902
Email: Risk.Management@uhc.com

We must be able to verify your participation prior to the cancellation date. Please allow at least five (5) business days to process your information. Note that you may receive renewal information separately while you complete this request. However, if we cannot confirm your participation requirements, that renewal information is not valid.

All forms and tax documentation submitted are considered confidential and proprietary and will be used only in the Risk Management Department for verification of participation and eligibility requirements.

Your assistance is vital and we appreciate your cooperation. If you have any questions regarding this request, please contact us via email at Risk.Management@uhc.com or by phone at 877-504-1179 x25609. Please include your name, group number, and telephone number with any messages.

Risk Management

CC:

Enclosures (Employer Information Form and envelope)

Need individual coverage? Call your Agent or Golden Rule at 1-800-693-3910. Golden Rule, a UnitedHealthcare company, offers health insurance for individuals and families not covered by group plans, available in most states.

Employer Information Form

UnitedHealthcare®

Employer (legal) Name & DBAs:	Customer/Group#:	Federal Tax ID #:
Nature of Business (products sold / service provided):	Email Address:	Telephone #:
Current Administrative Location of Your Business (if multiple locations, please list all locations):	Billing Address:	

Type of Business Organization (check box below):

☐ Sole Prop. ☐ S-Corp. ☐ C-Corp. ☐ LLC ☐ LLP (Partnership) ☐ Farm ☐ Non-Profit

1. Is the Group continuing to meet the contribution guidelines defined in your benefit contract? (circle one)
YES / NO

2. Do you offer coverage to your contracted 1099 employees? (circle one) *If Yes, please provide the most recent 1099 forms.
YES / NO / NA

3. Do you file a consolidated tax return as an affiliated group? (circle one) *If Yes, please provide the most recent **Form 851.**
YES / NO

4. 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 employee(s)? (circle one)
YES / NO

If you answered Yes, then by signing this form, you agree with the certification in this section:
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.

We require **the most recent copy** of your state **Quarterly Wage & Tax Report (QWR). Next to each employee listed on the QWR, please indicate the following:**

- State of residency
- Status code (from the list below)
- Date of hire or termination date (if applicable)

The submitted documents **must identify all employees, owners, partners & contracted employees** of your business, **not only those who have coverage with UnitedHealthcare and/or its affiliates**.

If your company does not file a Quarterly Wage & Tax Report (QWR) or you have employees or owners who are not listed on the QWR, please submit the following tax documentation where applicable:

- Sole Proprietorship – IRS Schedule C (Form 1040) or Schedule F (farms)
- S-Corporation – IRS Schedule K-1 (Form 1120S)
- C-Corporation – IRS Form 1120 (pg 1-2), including Schedule E & Schedule K #5
- Partnership / LLP – IRS Schedule K-1 (Form 1065)
- LLC – Appropriately filed IRS schedule(s)
- Non-Profit – Most recent quarter federal Form 941 and current 2-week payroll
- Contracted Employees – Form 1099 for all contracted employees (only if you offer coverage to such employees)
- New Hires – Most recent 2-week payroll report

Status Codes

A	Employee is actively enrolled (plan subscriber).	**S**	Employee is covered under spouse's employer plan.
M	Employee is covered under Medicare.	**O**	Employee has other coverage. Specify nature of coverage (e.g., individual, group, military, parental, etc.)
T	Employee is terminated (no longer works for this employer).	**D**	Employee is declining coverage (i.e., due to cost or doesn't want). Only use this code if the employee is full-time with no other coverage or waiver reason.
P	Employee is part-time and works less than the required full-time hours (includes temporary and seasonal employees).	**L**	Employee is not actively working due to Leave of Absence or other reason. Please provide the last tax form or payroll the employee is listed on.
W	Employee is full-time but is in the policy's waiting period. Indicate date of hire and date the employee will be eligible for coverage.	**C**	Person is covered under state or federal (COBRA) continuation law. Indicate continuation start date and whether coverage is provided by a prior employer or by your company.

THE UNDERSIGNED EMPLOYER, OR DULY AUTHORIZED REPRESENTATIVE, CERTIFIES THAT THE FOREGOING INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE OR BELIEF, AND FULLY UNDERSTANDS THAT ANY FALSE STATEMENTS OR FAILURE TO PROVIDE ALL AVAILABLE INFORMATION MAY CONSTITUTE THE BASIS FOR TERMINATION OF COVERAGE AT THE OPTION OF THE INSURER AND/OR THE GROUP POLICY'S ADMINISTRATIVE REPRESENTATIVE.

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