For use with groups installed on the

FACETS, ACIS/UNET PLATFORMS

Specialty Combined Group Application

Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Voluntary AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance, Critical Illness Insurance, Accident Insurance, and Hospital Indemnity Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

Requested Effective Date of Coverage: 01/01/2023

GENERAL INFORMATION

Group's Full Legal Name: Town of Prosper				
Street Address: 250 W. First Street		City: Prosper	State: TX	Zip Code: 75078
Contact Name: James Edwards	Phone Number: 972-569-1005	Fax Number:	E-Mail: JEdwards@prospertx.gov	
Billing Address (If Different):				
Billing Contact: Cindy Slate		Billing Contact Phone: 972-569-1020		
Tax ID Number: 756000642	Nature of Business/Organization: Municipality			
List all subsidiaries to be included:				
Organization Type: ☐ Corporation ☐ Partnership	☐ Political Subdivision	☒ Other*: Public Entity *Other group types may be subject to regulatory approval.		
Deposit: $ _____ Any deposit submitted with application is applied toward 1st month's premium (divided equally among all products if issued).				

ELIGIBILITY / PARTICIPATION

Total Number of Eligible Employees:	280	Minimum # of hours worked per week to be eligible for coverage	30+
Total Number of full-time Employees:	280	Minimum # of hours worked per week to be eligible for Disability coverage if different from the above*	

*For disability products the minimum # of hours per week to be eligible is 30 hours.

PLAN SELECTION AND INFORMATION

Products	Check your selection and fill in the Amount	% Premium contribution by Group		Subject to ERISA?
		Employee	Dependents	
Group Life				☐Yes ☐No
• Basic Life	☐ _____	____%	N/A	
• Basic AD&D	☐ _____	____%	N/A	
• Supplemental Life	☐ _____	____%	N/A	
• Supplemental AD&D	☐ _____	____%	N/A	
• Basic Dependent Life	☐ _____	N/A	____%	
• Basic Dependent AD&D	☐ _____	N/A	____%	
• Supplemental Dependent Life	☐ _____	N/A	____%	
• Supplemental Dependent AD&D	☐ _____	N/A	____%	
Short Term Disability	☐ Core _____	____%	N/A	☐Yes ☐No
	☐ Buy up _____	____%	N/A	
Long Term Disability	☐ Core _____	____%	N/A	☐Yes ☐No
	☐ Buy up _____	____%	N/A	
Critical Illness	☒ _____	0 %	N/A	☐Yes ☒No
Accident Protection	☒ _____	0 %	N/A	☐Yes ☒No
Voluntary AD&D	☐	____%	____%	
Hospital Indemnity	☐ Base	____%	N/A	☐Yes ☒No
	☒ Base + Enhanced	0 %	N/A	
	☐ Core	____%	N/A	

REPLACEMENT / PRIOR COVERAGE INFORMATION

Products	Do you intend to use this policy to replace a similar plan?	Prior Carrier's Name	Prior Policy #	Termination Date
Group Life	☐Yes ☐No			
Short Term Disability	☐Yes ☐No			
Long Term Disability	☐Yes ☐No			
Critical Illness	☒Yes ☐No	Allstate	21421	12/31/22
Accident Protection	☒Yes ☐No	Allstate	21421	12/31/22
Voluntary AD&D	☐Yes ☐No			
Hospital Indemnity	☒Yes ☐No	Allstate	21421	12/31/22

PRODUCER INFORMATION

Producer Name: Lance Pendley		Agency: McGriff Insurance	
Producer Signature:		Date: 11.1.2022	
Street Address: 5080 Spectrum Drive, Ste 900E	City: Addison	State: TX	Zip Code: 75001
Phone Number: 469-232-6612	Fax Number:	Email Address: lpendley@mcgriff.com	
Producer Number: 20-0468966	Tax ID Number:		
Commissions Payable To: McGriff Insurance Services		Commission split % (if applicable):	
Name Specific Commission Schedule :			

Note: **Provide information in a separate sheet if more than one producer.**

GENERAL AGENT INFORMATION

General Agent Name:		Tax ID Number:	
Street Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:	
Commissions Payable To :		G.A. Override:	

PRODUCER COMPENSATION DISCLOSURE

UNITEDHEALTHCARE INSURANCE COMPANY DISCLOSURE REGARDING PRODUCER COMPENSATION:
In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, if applicable, are reflected in the premium rate.

In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

AGREEMENT

The Group and UnitedHealthcare Insurance Company ("we", "us" or "our") agree that: THE APPLICATION shall form the basis for and become part of any policy issued. PREMIUM RATES shall: (1) be subject to all provisions in that policy; and (2) be binding on both Employer and us. LIABILITY OF THE COMPANY – We will have no liability until this request has been approved at Our Administrative Office. AUTHORITY OF AGENTS – No agent can change the terms of this request or any policy we issue. No agent can waive any of our rights or requirements or extend the time for any premium payments. CHANGES AND CORRECTIONS – The acceptance of any policy issued on this request shall constitute ratification of any correction or amendment made by us. Changes are an amendment to and form a part of the original request and any policy issued.

I UNDERSTAND AND AGREE: that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If my coverage is approved, premium is payable monthly in advance.

I represent that, to the best of my knowledge, the information I have provided in this Application is accurate and truthful. I understand that the Company will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences permitted by law. I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees/members and their dependents in providing coverage under this policy.

I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees/members or their dependents, including the addition of newly eligible employees/members or dependents. I understand and agree that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the Group's employees/members.

The Critical Illness and Accident Protection Plan coverages are NOT considered "minimum essential coverage" under the Affordable Care Act and therefore do NOT satisfy the mandate to have health insurance coverage. Failure to have other health insurance coverage may be subject to a tax penalty. Please consult a tax advisor.

GROUP SIGNATURE (form must be signed)

Group Authorized Person's Name (Print):	Title:
Group Authorized Person's Signature:	Date:

FRAUD WARNING NOTICES	Please review the notice that applies in your state.

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For residents of California (Health products): UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For residents of California (Life products): For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Connecticut: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For residents of Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated State law.

For residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UnitedHealthcare Electronic Delivery Consent Notice

UnitedHealthcare is required to provide certain information to the Employer before the Employer agrees to receive electronic communications.

This notice applies to all Internet-based communications from UnitedHealthcare, including email, website and mobile applications.

Electronic communications include, but are not limited to:

- Group Contracts (including Policy documents, Certificate of Coverage ("Certificates") any attached Application, and any Certificate Rider, endorsement or amendment.

Electronic Delivery of Communications

By choosing electronic delivery the Employer will receive communications electronically instead of receiving a paper copy.

The types of communications available electronically are subject to change, and if additional communications become available in an electronic format, the Employer will receive those communications electronically. Occasionally, in addition to electronic communications the Employer may also receive a hard copy document.

By signing below the Employer acknowledges receipt and accepts the terms of such Notice.

This consent remains in effect until it is withdrawn. The Employer may withdraw their consent at any time.

The Employer has the option to request that UnitedHealthcare provide the printed Group Contract and/or a supply of printed Certificates for the Employer to distribute to each Employee. A request for the printed Group Contract and/or a supply of printed Certificates can be made on the New Case Information Checklist that UnitedHealthcare will send to the Employer for completion, prior to producing the Group Contract.

If UnitedHealthcare attempts to deliver information to an email address the Employer provides and the message is returned as undeliverable after several attempts, UnitedHealthcare will assume that consent for electronic delivery has been withdrawn and will begin sending the information in a paper format.

Requirements to Access and Retain Information

In order to receive and retain electronic communications, the Employer must have access to a computer or other device which is capable of accessing the Internet and must have software which permits the access of Portable Document Format or "PDF" files, such as Adobe Acrobat Reader® version 6.0 or higher (available for downloading at http://get.adobe.com/reader). Click here for the list of supported: browsers

GROUP SIGNATURE (form must be signed)	
Group Authorized Person's Name (Print):	Title:
Group Authorized Person's Signature:	Date:

FOR USE WITH FACETS INSTALL ONLY OF GROUPS WITH 100+ LIVES

Group Life Insurance Transition Requirements

At UnitedHealthcare we are committed to partnering with you to implement and administer your benefit plan. In order to effectively implement your plan, we need the following important information.

1. **Actively at Work Rules and Requirements:** Identifying employees who are not Actively at Work* helps prevent any coverage issues before they occur. Existing coverage is transferred on a "no loss/no gain" basis on the Plan Effective Date for employees *who are Actively at Work* and dependents not confined in a hospital or medical facility. Employees who are *not Actively at Work* on the Plan Effective Date will not be covered until they have returned to work. Dependents who are confined to a hospital or medical facility on the Plan Effective Date (other than a newborn child) will not be covered until the day following discharge.
Payment of premium for an employee who is not Actively at Work does not guarantee coverage for that employee.

2. **List of Employees Not Actively at Work:**
   a. If you do **not** intend to request that we provide coverage for Employees who are not Actively at Work, please forward a complete, up to date census indicating the status of each Employee.
   b. If you are requesting we provide coverage for Employees not Actively at Work, you must use the list below and fill in all information. **We will evaluate this list and indicate whether we will or will not provide coverage for each person on the list. Based on our decision, we reserve the right to make adjustments to our proposal.**

PLEASE NOTE: REQUESTS TO WAIVE THE ACTIVELY AT WORK REQUIREMENT WILL NOT BE COMPLETE AND EMPLOYEES WHO ARE NOT ACTIVELY AT WORK ON THE PLAN EFFECTIVE DATE WILL NOT BE COVERED UNTIL WE HAVE RECEIVED AND EVALUATED THE LIST.

Remember, if you have waiver of premium in your current contract, all claims falling under that provision should be submitted to your prior carrier before contract cancellation or affected Employees should be offered conversion under their conversion provision.

To be completed by the Policyholder –
Are you requesting waiver of the Actively at Work requirement stated in item 1 above? ☐ ***Yes*** *(see below)* ☐ ***No***

Yes, for the following employees:	***Yes, we will provide the list of employees by (enter date) _____.*** **Note:** this information date will not be accepted beyond 30 days after the Plan Effective Date.							***To be completed by UHCSB Underwriting***
Employee Name	***Date of Birth***	***M /F***	***Last Day Worked***	***Total Amount of Group Life Insurance***	***Reason not Actively at Work***	***Anticipated Return to Work Date***	***Leave approved through: (date)***	***UHCSB to Provide coverage Premium required***

(Please use separate sheet if necessary)

3. **Copy of the prior Carrier Contract or Certificates:** Please provide a copy of the prior carrier's contract or certificates. **Special Situations:** Please let your UHCSB Representative know if there are any special agreements or amendments to the prior carrier contract such as grandfathered or retired employees. All special situations must be approved by UHCSB.

Signature and Acknowledgement (To be signed by authorized representative of policyholder)

Policyholder Name	***Group Policy Number***	***Date***
Name of person completing this form	***Signature (on behalf of Policyholder)***	
UHCSB Underwriter Name:	***Date:***	

Policyholder: Please keep a copy of this document for your records

*For the purposes of determining eligibility under the Plan, Employees will be considered Actively at Work if they report for work at their usual place of employment and are able to perform the material and substantial duties of their regular occupation for the entire normal workday. Unless disabled on the prior workday or on the day of absence, Employees will be considered Actively at Work on the following days:

a. a Saturday, Sunday or holiday which is not a scheduled workday;
b. a paid vacation day, or other scheduled or unscheduled non-workday; or
c. an excused or emergency leave of absence (except medical leave.)

If our definition of Actively at Work conflicts with the Employer's definition, for the purpose of determining eligibility under the Plan, our definition will prevail.