UnitedHealthcare
Risk Mgmt MN017-E700, 9700 Health Care Ln
Minnetonka MN 55343-4527

ACTION REQUIRED

075RMLETR0072001-00980-01
TOTAL BENEFIT SOLUTIONS INC
427 E STREET RD
FEASTERVILLE TREVOSE PA 19053-7715

March 15, 2021

Re: Eligibility Verfication

Group Name: CLAY'S CREATIVE CORNER BAKERY
Group Number: 5Y6453
Cancel Date: 05/01/21

Please see next page.

UnitedHealthcare®
Risk Mgmt MN017-E700, 9700 Health Care Ln
Minnetonka MN 55343-4527

ACTION REQUIRED

CLAY'S CREATIVE CORNER BAKERY
LINDSAY BONES
700 LANCASTER AVENUE
BERWYN PA 193120000

Group Number: 5Y6453
Group Name: CLAY'S CREATIVE CORNER BAKERY
Cancel Date:05/01/21

March 15, 2021

Dear LINDSAY BONES,

We sent you a request to verify that you meet the participation and/or eligibility requirements to continue your coverage. Our records show that you have not responded or you have provided incomplete information.

Enclosed is another copy of the verification request forms. This is your last notice. Your coverage will be canceled on **May 1, 2021** if you do not respond, and meet eligibility requirements before then.

What do I need to do to prevent coverage cancellation?

As soon as possible (and before the cancel date shown above), complete the following steps:

1. Complete the attached Employer Information Form and Common Ownership Certification, and have an officer of your company sign and date the forms.
2. Gather the requested tax documentation.
3. Indicate the status of each employee directly on the tax form(s) you send.
4. Return the completed forms and documents to any of the following:

   Email: risk.management@uhc.com

   Fax: 1-877-232-7902

   Mail: **UnitedHealthcare**
   Attn: Risk Management MN017-E700
   9700 Health Care Lane
   Minnetonka, MN 55343-4527

What happens next?

Once we verify your information, we'll send you a letter with an update. If you get renewal information before we've verified your eligibility, that renewal information will not be valid.

What if I already sent you this information?

Please allow five 5 business days to process your information. If you need more information or a status update on our review, please visit our website at **uhc.com/rm**.

If my coverage is cancelled, do I still need to pay for current coverage?

Yes. Since coverage is provided up to the cancellation date, you must pay the balance due up to that date. If there is a balance on your policy, we will mail you a Statement of Account. It will include any balance due because of monthly bills not yet processed on the cancellation date and any employee additions or changes.

What if I've paid premiums for coverage after the cancellation date?

We will process those premium payments and refund them to you.

Note: If your plan involves employee contributions that have already been collected for benefits beyond the cancellation date, you will be responsible for those benefits.

Will any coverage extend beyond the cancellation date?

UnitedHealthcare is not liable for claims or losses incurred on or after the cancellation date of the policy (except for extended benefits due to total disability).

What do my employees need to know?

You must tell your employees immediately that their coverage will end on **May 1, 2021**. Also, please give them the following information regarding conversion rights:

> Check your contract documents to find out what conversion rights you may have. *Conversion* means switching your job-based coverage to an individual policy. To exercise your conversion rights, call the Conversion Customer Service unit at **1-866-747-1019**, TTY **711**. You must elect conversion coverage within 31 days of **May 1, 2021**.

Note: Individual or family plans may not be available in all states.

Can I apply for a small employer health insurance policy?

Yes. Federal law has set an open enrollment period from November 15 to December 15 of each year for new small employer businesses. During this time, groups that don't meet participation requirements may apply for a small employer health insurance policy. Please contact your broker or agent with questions.

What if I have other questions?

You can call us toll-free at **1-877-504-1179 x37768**, TTY **711**, visit our website at **uhc.com/rm**, or email us at **risk.management@uhc.com**. Please include your name, group number, and phone number with any messages.

Sincerely,

Risk Management

Enclosures: Employer Information Form, Common Ownership Certification

Insurance coverage provided by or through UnitedHealthcare Insurance Company, or their affiliates.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果? 說中文(Chinese), **我們免費為?提供語言協助服務。請撥打會員?所列的免付費會員電話號碼。**

UnitedHealthcare®

Employer Information Form

SECTION A		
Employer (legal) **Name & DBAs:**	**Customer/Group#:** **5Y6453**	**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.uhc.com/rm
Email Address	risk.management@uhc.com
Fax Number	1-877-232-7902
Toll-Free Phone Number	1-877-504-1179 x37768

***** Include your group number in all correspondence - 5Y6453 *****

Common Ownership Certification

UnitedHealthcare®

Please complete, sign and submit the Common Ownership Certification.

Renewing Groups- complete and return even if you do not have multiple companies.

Please list all companies that are eligible to be included as part of a consolidated federal tax return (even if they don't file a consolidated federal tax return) or who are part of a controlled group as defined under the Internal Revenue Code. *When listing the number of Eligible, count the number of Eligible employees for each business, even if they're not offered this insurance.

Customer Name: _____

Group Number (if renewal): 5Y6453

Primary Business Location: _____

Please check one of the following:

☐ I certify that my business applying for coverage with UnitedHealthcare is **not** part of a controlled group (commonly owned or affiliates) as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder. (Single business that has no common ownership/affiliates)

Or

☐ I certify that my business(es) applying for coverage with UnitedHealthcare (1) is eligible to file a consolidated federal tax return or (2) meets the IRS test for being a controlled group as defined under the Internal Revenue Code sections 414 (b),(c),(m),(o) or 1563 and the Treasury regulations issued thereunder .I further certify there are no other affiliated entities, other than the ones listed below, who are part of the controlled group that includes my business.

	Business Name:	Federal Tax ID #:	# of Eligible*:	On This Policy:
1.				Yes / No
2.				Yes / No
3.				Yes / No
4.				Yes / No
5.				Yes / No
6.				Yes / No

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: