Financial Protection Product Administration Guide

New York

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In the event of conflicting information in this administration guide, refer to the group policy and individual certificate for resolution.

Life and Disability insurance products are underwritten by Unimerica Life Insurance Company of New York. Accident Protection Product and Specified Disease insurance is provided by Unimerica Life Insurance Company of New York. Specified Disease coverage is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does 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. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Unimerica Life Insurance Company of New York is located in New York, NY.

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Welcome

Thank you for selecting Unimerica Life Insurance Company of New York for your insurance needs.

Contact and Mailing Information

The most frequently used contact numbers and addresses are listed below.

Topic	Contact
Billing	**Inquiries/Questions:** Customer Service: 866-322-1210 Opt #1 Email: life_billing@uhc.com Fax: (877) 766-1608
Claims	**Life Claims** Customer Service: (888) 299-2070 Fax: (800) 980-0298 Mailing Address: Unimerica Life Insurance Company of New York P.O. Box 7149 Portland, ME 04112-7149 **Disability Claims (STD/LTD)** STD Customer Service: (866) 556-8298 Fax: (888) 505-8550 LTD Customer Service: (888) 299-2070 Fax: (800) 980-0298 Mailing Address: Unimerica Life Insurance Company of New York P.O. Box 7466 Portland, ME 04112-7466

Topic	Contact
Claims	**<u>Specified Disease Plan Claims</u>** Customer Service: (866) 556-8298 Fax: (888) 505-8550 Mailing Address: Unimerica Life Insurance Company of New York P.O. Box 7466 Portland, ME 04112-7466 **<u>Accident Protection Plan Claims</u>** Customer Service: (866) 556-8298 Fax: (888) 505-8550 Mailing Address: Unimerica Life Insurance Company of New York P.O. Box 7466 Portland, ME 04112-7466 **<u>Hospital Indemnity Management Requests</u>** Customer Service: (888) 299-2070 Fax: (800) 980-0298 Mailing Address: UnitedHealthcare P.O. Box 7466 Portland, ME 04112-7466 **<u>FMLA and Leave Management Requests</u>** Customer Service: (866) 556-8298 Fax: (888) 505-8550 Mailing Address: Unimerica Life Insurance Company of New York P.O. Box 7466 Portland, ME 04112-7466
Conversion	**<u>Life Conversion</u>** Conversion Customer Service: (888) 999-4767

	Fax: (978) 762-4767 Mailing Address: HRMP Life Conversion Facility 300 Rosewood Drive, Suite 250 Danvers, MA 01923

Topic	Contact
Enrollment	**<u>Life/Disability/Specified Disease/Accident</u>** Customer Service: (866) 322-1210 Opt #4 Email: life_eligibility@uhc.com Fax: (855) 695-3472 or (612) 367-0985 Mailing Address: Unimerica Life Insurance Company of New York MN017-W700 9700 Healthcare Lane Minnetonka, MN 55343
Evidence of Insurability	**<u>Inquiries/Questions</u>** Customer Service: (866) 615-8727 Opt#3 Opt#1 Email: eoi_underwriting@uhc.com Fax: (855) 290-5224 Mailing Address: Unimerica Life Insurance Company of New York Group Medical Underwriting Services PO Box 17829 Portland, ME 04112

List Billed Group Administration Guidelines

Enrollment Checklist

Please use this checklist to ensure that you meet the group enrollment administrative requirements.

- ❑ Review **Enrollment Form** for legible, complete and accurate information prior to forwarding to Unimerica Life Insurance Company of New York.
- ❑ Be sure the employee has signed and dated the form.
- ❑ Complete the section marked 'Completed by the Employer.'
- ❑ Check that all necessary information has been provided, such as (but not limited to):
    - Effective date of coverage
    - Company Name and Division/Billing Location
    - Social Security Number or alternate ID
    - Date of full-time employment or rehire date
    - Salary and salary mode
    - Employee's job title
    - Date of birth
    - Gender
    - Employee's full home address and telephone number
- ❑ If applicable,
    - Check that Beneficiary Information is completed.
    - For contributory plans (Employee Paid) all desired insurance is checked.

Enrollment of New Hires

How do I enroll a new employee?

1. Complete an **Enrollment Form** immediately after a new employee is eligible for insurance. This serves as the basic insurance record. Double check the form to be sure it is filled out completely. Unimerica Life Insurance Company of New York may return incomplete forms.
2. Keep a copy for your records.
3. Fax or mail the form to Unimerica Life Insurance Company of New York.
4. All forms must be received within 60 days of the employee's effective date.

FAX completed forms to: (855) 695-3472	OR	**MAIL** completed forms to: Unimerica Life Insurance Company of New York MN017-W700 9700 Healthcare Lane Minnetonka, MN 55343
☐ Do not mail enrollment forms with your premium payment. ☐ Do not mail the originals if you have faxed your enrollments.		

What are the guidelines for Non-Contributory insurance?

If the **employer pays the full cost of insurance**, 100% of all eligible employees must be enrolled. Eligible employees cannot waive non-contributory insurances.

What are the guidelines for Contributory insurance?

- ☐ If the **employee pays any portion of the cost** of insurance, the employer should offer the employee the insurance.
- ☐ If insurance is elected, complete and submit an Enrollment Form.
- ☐ The employee's signature serves as the payroll deduction authorization.

Enrollment of Rehired Employees

Who is considered to be a rehired employee?

Any employee who returns to work after temporary termination may request insurance.

How do I enroll a rehired employee?

1. Complete a new **Enrollment Form** and include the rehire date* and current information. Double check the form to be sure it is filled out completely. Unimerica Life Insurance Company of New York may return incomplete forms.
2. Keep a copy for your records.
3. Fax or Mail the form to Unimerica Life Insurance Company of New York.
4. All forms must be received within 60 days of the employee's effective date.
5. Begin payroll deductions after receiving the Notice of Approval.

FAX completed forms to: (855) 695-3472	OR	**MAIL** completed forms to: Unimerica Life Insurance Company of New York MN017-W700 9700 Healthcare Lane Minnetonka, MN 55343

- Do not mail enrollment forms with your premium payment.
- Do not mail the originals if you have faxed your enrollments.

Why is the rehire date important?

The rehire date will be used to determine eligibility, unless otherwise noted in the group insurance policy.

*The rehired employee may be considered a late applicant if applying for insurance more than 31 days after the date of eligibility. See Enrollment of Late Applicants Administration Guidelines.

Enrollment of Late Applicants

Who is considered to be a late applicant?

Any employee who applies for insurance more than 31 days after the date of eligibility is considered to be a late applicant.

Life, and Disability and Specified Disease

Non-Contributory Insurance (Employer-paid)	Contributory Insurance (Employee-paid)
In the event an administrative error accidentally leaves an employee off the company's remittance to the insurer, insurance for the unintentionally omitted employee will be made effective on the employee's original effective date. Your company must pay all back premiums.	The employee must submit the following completed forms: ☐ Enrollment form ☐ Evidence of Insurability form for late applicants The employee will be added after Unimerica Life Insurance Company of New York sends a written Notice of Approval. If evidence of insurability was required, do not begin payroll deduction until you receive written Notice of Approval.

When is Evidence of Insurability required?

Evidence of insurability is required for employee who elects:

- ☐ An initial benefit amount of insurance that's more than the guarantee issue amount
- ☐ Any amount of insurance more than 31 days after his or her initial eligibility date
- ☐ A benefit increase, of any amount, after his or her initial election

How does Evidence of Insurability affect Guarantee Issue?

The amount not subject to evidence of insurability is the maximum benefit Unimerica Life Insurance Company of New York will underwrite without requiring evidence of insurability. The amount not subject to evidence of insurability is only available during the first 31 days an employee is eligible for insurance. Any employee not applying within that time frame must complete Evidence of Insurability for any amount of coverage, including the Guarantee Issue amount.

- ☐ Evidence of insurability is required should the employee request a benefit amount or benefit increase, which exceeds the Guarantee Issue amount.
- ☐ An Evidence of Insurability form must be submitted and the excess benefit amount will be underwritten.

Note: Do not begin deducting any amounts/increases until you receive a written Notice of Approval.

Evidence of Insurability is not required for Specified Disease, Accident or HIPP

Reporting Adjustments and Changes

How do I report changes and adjustments?

Use the **Enrollment Form** to report any of the following changes as they occur:

- ☐ Terminations of employee benefits
- ☐ Occupational class changes
- ☐ Salary changes (if benefit is salary based see below)
- ☐ Name change
- ☐ Marital status change
- ☐ Dependent insurance change

1. Complete an Enrollment Change Form immediately before the first of each month.
2. Keep a copy for your records.
3. Fax or mail the form to Unimerica Life Insurance Company of New York.
4. All forms must be received within 60 days of the change effective date.
5. Enrollment forms must be received 5 business days prior to the 15th of the month to be included in the next month's invoice.

FAX completed forms to: OR (855) 695-3472	**MAIL** completed forms to: Unimerica Life Insurance Company of New York MN017-W700 9700 Healthcare Lane Minnetonka, MN 55343
▪ Do not mail enrollment forms with your premium payment. ▪ Do not mail the originals if you have faxed your enrollments.	

How do salary changes affect premium?

Premium will be adjusted based on reported salary changes. Report salary changes as they occur on all employees whose insurance is determined according to their earnings.

How do additions and terminations affect premium?

- ☐ If an employee terminates after the premium due date, premiums are due for the entire month.

- ☐ If an employee is effective on or before the 15th of the month, premium will be charged for the entire month. If the employee is effective after the 15th of the month, premium will not be charged until the next premium due date. Unimerica Life Insurance Company of New York does not prorate premium.

How do I add new employees resulting from merger or purchase of another company?

Notify your broker and your Unimerica Life Insurance Company of New York regional sales office. Provide the following information:

- ☐ Complete census or Enrollment Forms
- ☐ Date of acquisition
- ☐ Name of acquisition
- ☐ Effective date of insurance

Billing Statements and Premium Payment Procedure

When will I receive a Billing Statement?

You will receive a billing statement ten days prior to the premium due date.

What does the Billing Statement include?

Clients who have selected list billing will receive statements that include:

- ☐ A list of each insured employee listed under the plan and premium date.
- ☐ A report of adjustments made from the previous month's statement, including a Summary page.

Check your statement carefully to ensure all eligible employees are included on the statement and that the benefits are correct.

How do I mail premium payments?

It is very important to pay as billed. Your premium is due on or before the due date listed on your billing statement.

- ☐ To ensure proper credit on your account, you must use the Invoice Remittance page provided as the top of the cover sheet for the bill.
- ☐ If you have more than one bill coming to your address, send all Invoice Remittance pages with your payment.
- ☐ Document changes on the detailed invoice and submit along with your premium payment. (For new enrollment, refer to the Enrollment Administrative Guidelines.)

☐ Mail premium payments as indicated below.

MAIL payments to:	**OVERNIGHT** payments to:
Unimerica Life Insurance Company of New York P.O. Box 860511 Minneapolis, MN 55486-0511	Unimerica Life Insurance Company of New York Lockbox 860511 1200 Energy Park Drive St Paul, MN 55108
▪ To avoid delays in posting your payment to your account, do not mail your payment to our street address.	

Forms for List Billed Groups

As the plan administrator, you should be familiar with several forms, including the following:

☐ Enrollment form

☐ Evidence of Insurability form

Self Billed Group Administration Guidelines

Enrollment Checklist

Please use this checklist below to ensure that you meet the group enrollment administrative requirements.

- ❑ Complete an **Enrollment Form** for each new employee hired.
    - The Enrollment Form serves as the basic insurance record.
    - Employee's signature serves as the payroll deduction authorization.
- Check that all necessary information has been provided, such as (but not limited to):
    - Effective date of coverage
    - Company Name and Division/Billing Location
    - Social Security Number or alternate ID
    - Date of full-time employment or rehire date
    - Salary and salary mode
    - Employee's job title
    - Date of birth
    - Gender
    - Employee's full home address and telephone number
- ❑ File the completed Enrollment Form with your office records.
- ❑ Be sure to keep current beneficiary designation records for Life Insurance.
- ❑ **Do not fax or mail** to Unimerica Life Insurance Company of New York (except for late entrants).
- ❑ When a claim is filed, in order to ensure that Unimerica Life Insurance Company of New York will consider paying full benefits, you are required to submit necessary records, including but not limited to:
    - Payroll records

      Enrollment Forms
    - Enrollment Forms indicating changes
    - Current beneficiary designations at the time of a claim submission

The plan administrator will be responsible for maintaining all policy and enrollment records as well as calculating, reporting and submitting premiums to Unimerica Life Insurance Company of New York.

Enrollment of Rehired Employees

Who is considered to be a rehired employee?

Any employee who returns to work after temporary termination may request insurance.

How do I enroll a rehired employee?

1. Complete a new **Enrollment Form** and include the rehire date and current information.
2. Add the rehired employee to the Statement of Premium Due.
3. The rehire date will be used to determine eligibility unless otherwise noted in the group insurance policy.

Rehired employees may still be considered to be late applicants if they apply for insurance more than 31 days after the date of eligibility (See Enrollment of Late applicants section).

Enrollment of Late Applicants

Who is considered to be a late applicant?

Any employee who applies for insurance more than 31 days after the date of eligibility is considered to be a late applicant.

Life, Disability and Critical Illness

Non-Contributory Insurance (Employer-paid)	Contributory Insurance (Employee-paid)
☐ 100% of all eligible employees must be enrolled. ☐ In the event an administrative error occurs and an employee is accidentally left off the company's remittance to the insurer, insurance for the late applicant unintentionally omitted employee will be made effective on the employee's original effective date. ☐ Your company must pay all back premiums. ☐ Eligible employees cannot waive non-contributory insurance.	The employee must submit the following completed forms: ☐ Enrollment form ☐ Evidence of Insurability form, for any insurance issued over the guarantee issue amount Do not begin payroll deduction until you receive written Notice of Approval.

Evidence of Insurability is not required for Specified Disease, Accident or HIPP

When is Evidence of Insurability Required?

Evidence of Insurability is required for employees who elect:

- ☐ an initial benefit amount of insurance that's more than the guarantee issue amount
- ☐ any amount of insurance more than 31 days after his or her initial eligibility date
- ☐ a benefit increase, of any amount, after his or her initial election.

A completed **Evidence of Insurability** form will be required for each employee and each dependent. The dependents may only be added to the plan after written approval is received.

How does Evidence of Insurability affect Guarantee Issue?

The Guarantee Issue limit is the maximum benefit we will underwrite without requiring evidence of insurability. The amount not subject to evidence of insurability is only available during the first 31 days an employee is eligible for insurance. Any employee not applying within that time frame must complete Evidence of Insurability for any amount of coverage, including the Guarantee Issue amount.

- ☐ Evidence of insurability is required should the employee request a benefit amount or benefit increase, which exceeds the Guarantee Issue amount.
- ☐ An Evidence of Insurability form must be submitted and the excess benefit amount will be underwritten.

Do not report the amount requested over the Guarantee Issue amount on the Statement of Premium Due until you receive a written Notice of Approval.

Billing Statements and Premium Payment Procedure

What are my responsibilities as Group Administrator?

- ☐ Monthly updating of information on the e-Bill system for each line of insurance at the subgroup level, including:
  - number of lives
  - volume
  - premium
  - age-banded products: counts, volumes, and premium if applicable

- ☐ Keeping all necessary paperwork in your office. **Do not fax or mail** forms to us. This includes, but is not limited to:
  - Enrollment Forms
  - Enrollment Forms indicating the change
  - Beneficiary Designation Forms

- ☐ Completing the Electronic Payment Authorization Form to utilize the on-line payment option using the e-Bill system.
- ☐ Submitting the Invoice Detail and payment, using the e-Bill system.

How do I complete the Statement of Premium Due?

The samples provided on the following page may not list the same products that are available as part of your group plan. These procedures are applicable for all lines of insurance that are self-billed.

Premium Calculation Examples

Rates and benefits shown on the next few pages are illustrative only. Please see your contract for actual benefit amounts.

Calculating Premium

Please follow the formulas included in the examples on the next few pages to calculate the premium due for a particular product. Refer to your schedule of benefits to determine the benefit amounts for your employees.

Example: Life/AD&D Insurance (Basic and Supplemental)

Life and AD&D monthly rates are usually per $1,000 of insurance. Base the premium calculations on the actual benefit amounts provided to each employee in thousands, taking into account age reductions where appropriate. Use this formula to calculate the cost:

Benefit Amount / 1,000 x Rate = Premium

Example #1 **Life Insurance for John Smith** 25,000 Benefit/1000 = 25 25 x $0.30 = $7.50	**Example #2** **Life Insurance for all employees of ABC, Inc.** 610,000 Benefit/1000 = 610 610 x $0.30 = $183.00
Example #3 **AD&D Insurance for John Smith** 25,000 Benefit/1000 = 25 25 x $0.05 = $1.25	**Example #4** **AD&D Insurance for all employees of ABC, Inc.** 610,000 Benefit/1000 = 610 610 x $0.05 = $30.50

Example: Dependent Life Insurance

Dependent Life insurance rates are either per family unit or per $1,000. In cases where the rate is per family unit, charge the same rate per family regardless of the actual number of dependents insured. Use this formula to calculate the cost of dependent life insurance when the rate is per family unit:

Family Unit x Rate = Premium

Example #1 **Dependent Life Insurance for John and Sara Smith and children** 1 family unit x $1.20 = $1.20	**Example #2** **Dependent Life Insurance for all families of ABC, Inc.** 20 family units x $1.20 = $24.00

Example: Long-Term Disability (LTD) Insurance

LTD monthly rates are per $100 of insured Monthly Covered Payroll (MCP). Base the premium calculations on MCP. Use this formula to calculate the cost of LTD insurance.

Monthly Earnings/100 x Rate = Premium

Example #1

LTD Insurance for Julie Johnson

According to the group policy, this plan will cover 60% of the MCP up to a maximum monthly benefit of $5,000 at a rate of $0.38 per $100 of MCP.

Julie's monthly earnings: $3,012
MCP insured by plan: $8, 333 (maximum monthly benefit divided by 60% of benefit).

Cost of Julie's insurance:

$3,012 monthly earnings/100 = $30.12

$30.12 x $0.38 = $11.44

Example #2

LTD Insurance for all employees of ABC, Inc.

According to the group policy, this plan will cover 60% of the Monthly Covered Payroll (MCP) up to a maximum monthly benefit of $5000 at a rate of $0.66 per $100 of MCP.

Step 1: Determine the MCP based on the plan design:

Take the Maximum Monthly Benefit and divide by the Benefit Percentage:

5,000 / 60% = $8,333 MCP Maximum

Step 2: Determine the MCP for each person. Anyone who exceeds the Monthly Covered Payroll Maximum calculated in Step 1 must be capped at that amount.

Census File	Annual Salary	Monthly Salary	Maximum MCP	Actual MCP
CEO	$500,000	$41,667	$8,333	$8,333
CFO	$280,000	$23,333	$8,333	$8,333
Managing Director	$50,123	$4,177	$8,333	$4,177
Clerk	$25,000	$2,083	$8,333	$2,083
Sales & Marketing	$65,000	$5,417	$8,333	$5,417

Total MCP	$28,343
Total MCP divided by 100	$283.43
Times rate per $100 of MCP	$0.66
Monthly Premium	$187.06
Annual Premium	$2244.77

Example: Short-Term Disability (STD) Insurance

STD monthly rates are per $10 of insured Weekly Covered Benefits (WCB). Base the premium calculations on WCB. Use this formula to calculate the cost of STD insurance:

Benefit Amount/10 x Rate = Premium

Example #1

STD insurance for John Smith

According to the group policy, this plan will cover 60% of weekly earnings (this percentage of earnings is also known as Weekly Covered Benefit (WCB). Assume in this example the maximum WCB is $1,500 and the rate is $0.44 per $10 of WCB.

John's weekly earnings: $750.00 John's WCB: $450 (60% of $750 Maximum weekly benefit: $1,500.

Cost of John's insurance:
$450.00 weekly earnings / 10 = $45.00

$45.00 x $0.44 = $19.80

Example #2

STD Insurance for all employees of ABC, Inc.

According to the group policy, this plan will cover 60% of the weekly earnings (this percentage of earnings is also known as Weekly Covered Benefit or WCB) up to a maximum WCB of $1,500 at a rate of $0.50 per $10 of WCB.

Step 1: The WCB maximum weekly benefit is $1,500.

Step 2: Determine the WCB for each person. Anyone who exceeds the maximum weekly benefit must be capped at that amount.

Census File	Annual Salary	Weekly Salary	WCB	Maximum WCB	Actual WCB
CEO	$500,000	$9,615	$5,769	$1,500	$1,500
CFO	$280,000	$5,385	$3,231	$1,500	$1,500
Managing Director	$50,123	$964	$578	$1,500	$578
Clerk	$25,000	$481	$288	$1,500	$288
Sales & Marketing	$65,000	$1,250	$750	$1,500	$750

Total WCB $4,616.00

Total WCB divided by 10 $461.60

Times rates $0.50

Monthly premium $238.80

Annual Premium.....$2,769.60

Example #3

STD Insurance for all employees of ABC, Inc. based on the

MCP method Monthly Covered Payroll (MCP) Method

Before using this example: *Please validate if your STD rate is based on the MCP method. If you are not sure or have questions, please contact the billing department or your Strategic Account Executive/Account Manager.*

Occasionally, STD premiums may be calculated using the method defined in the LTD Monthly Covered Payroll (MCP) example. **For example:**

According to the group policy, this plan will cover 60% of the Monthly Covered Payroll (MCP) up to a maximum weekly benefit of $1500 at a rate of $0.66 per $100 of MCP.

Step 1: Convert Maximum Weekly Benefit to Maximum Monthly Benefit:

Based on plan design, take Maximum Weekly Monthly Benefit, then multiply by 52, then divide by 12 to get the Maximum Monthly Benefit:

$1,500 x 52 weeks ÷ 12 months = $6,500 Maximum Monthly Benefit

Step 2: Convert Maximum Monthly Benefit to Maximum Monthly Covered Payroll:

Based on plan design, take Maximum Monthly Benefit from Step 1 and divide by benefit percentage:

$6,500 ÷ 60% = $10,833 Maximum Monthly Covered Payroll

Step 3: Determine the MCP for each person. Anyone who exceeds the Maximum Monthly Covered Payroll calculated in Step 2 must be capped at that amount.

Census File	Annual Salary	Monthly Salary	Maximum MCP	Actual MCP
CEO	$500,000	$41,667	$10,833	$10,833
CFO	$280,000	$23,333	$10,833	$10,833
Managing Director	$50,123	$4,177	$10,833	$4,177
Clerk	$25,000	$2,083	$10,833	$2,083
Sales & Marketing	$65,000	$5,417	$10,833	$5,417

Total MCP	$33,343.
Total MCP divided by 100	$333.43
Times rate per $100 of MCP	$0.66
Monthly Premium	$220.06
Annual Premium	$2,640.72

Example: FMLA & Leave Management

FMLA & Leave Management rates are calculated on a PEPM basis (Per Member Per Month). Base your calculations on the PEPM rates as noted on your invoice.

Use this formula to calculate the cost:

- PEPM rate x number of total covered employees

Forms for Self-billed Groups

As the plan administrator, you should be familiar with several forms, including the following:

- Enrollment Form
- Evidence of Insurability
- Statement of Premium Due
- Beneficiary Designation
- Electronic Payment Authorization Form
- Claim Form

Voluntary Life Insurance Administration Guidelines

Eligibility

Whom is voluntary life insurance offered?

- ☐ Employee Only
- ☐ Employee and Child
- ☐ Employee and Spouse
- ☐ Spouse Only
- ☐ Spouse and Child
- ☐ Employee, Spouse and Child

When are employees eligible?

Employees are eligible for insurance after completing the waiting period, if applicable. All new employees will be added to the bill effective the first of the month following completion of the waiting period or upon signing the **Enrollment Form**, whichever is later. There will be no mid-month premium calculation.

Note: Employees contractually have 31 days from the effective date to enroll. Please refer to your plan for specifics regarding effective date of coverage.

When do employees or dependents need to complete the medical questions?

Employees or dependents need to provide evidence of insurability if:

- ☐ They apply for an amount over the amount not subject to evidence of insurability, the Guarantee Issue amount.
- ☐ They did not enroll initially and are now requesting insurance. Applicants will be responsible for any medical fees incurred as late enrollees.
- ☐ Dependent insurance is over Guarantee Issue amount.
- ☐ Dependent applies for insurance after initially declining coverage.
  An employee wants to increase insurance for self or dependents.
- ☐ For employees within 31 days from a qualifying life status change due to a change in marital status (marriage, divorce, legal separation, annulment) or a change in the number of dependents for tax purposes (birth, legal adoption of a child, placement of a child with the employee for adoption or death of a dependent), elections:
  - Greater than one increment or;
  - One multiple of earnings or;
  - $50,000
  - Or exceeding the Guarantee Issue amount

Premium

How do I calculate an employee's age for premium purposes?

Calculate the premium based on the employee's age on the eligibility date. If a person's age changes from one age band to another, premium will not increase until the employer's next policy anniversary date or the month following the date of change, depending on the method in place for your plan. Please refer to your policy for specifics.

What is the deduction amount?

Deduct premiums to cover the amount not subject to evidence of insurability. Upon approval, begin deductions to the full amount of premium.

Life Policies Administration Guidelines

Claim Submission

For assistance regarding life claims, please contact a Claims Representative at 1-888-299-2070 or fax (800) 980-0298.

The AD&D benefit does not apply to all life insurance. Please see your policy to determine whether this feature applies to you.

How do I submit a death claim?

1. The claimant is responsible for completing the Claimant portion (Section 1) of the **Proof of Death Form.**
2. Complete the Employer or Plan Administrator portion (Section 2) of **the Proof of Death** form.
3. Include a certified death certificate with the death claim. Typically, a photocopy of the certified death certificate is acceptable; however, an original copy may be needed in some instances. Mail or fax the completed Proof of Death form and the certified death certificate to the address or the fax number provided on the claim form.
4. If the death was not a result of natural causes (i.e. accident, homicide) a copy of the official report (i.e. police, accident, coroners, toxicology, fire, FAA, OSHA) must be provided in order to consider payment of the AD&D benefit.
    - ☐ AD&D benefits cannot be paid on any claim without an investigative report regarding the insured person's/dependent's death.
    - ☐ If your AD&D policy contains alcohol or drug exclusions, a toxicology report will be required.
5. Claim submissions must also include:
    - ☐ Enrollment Form
    - ☐ Copies of any beneficiary changes
    - ☐ Absolute Assignments* (if applicable)
    - ☐ Funeral Assignments (if applicable)

MAIL completed forms to:
Unimerica Life Insurance Company of New York
P.O. Box 7149
Portland, ME 04112-8829
Or
EMAIL completed forms to:
fpcustomersupport@uhc.com

* An Absolute Assignment is used to change certain ownership rights of a policy and must be signed by the current owner of the policy. The new owner will have the right to change the beneficiary designation. Ownership is usually transferred for tax

purposes.

How do I submit a dismemberment claim?

1. Complete the Employer portion of the Statement of Claim for Accidental Dismemberment Benefits form.
2. Ask the insured person to:
   - ☐ Complete the employee portion of the claim form.
   - ☐ Have the insured's physician complete the attending physician's statement on the claim form.
   - ☐ Provide a copy of the accident report.
   - ☐ Provide a copy of the toxicology report (if one is performed).

MAIL completed forms to:
Unimerica Life Insurance Company of New York
P.O. Box 7149
Portland, ME 04112-8829
Or
EMAIL completed forms to:
fpcustomersupport@uhc.com

Beneficiary Information

How do I complete a funeral home assignment?

A funeral home assignment means the beneficiary (or beneficiaries) has assigned all or a portion of the policy benefits to a funeral home in order to cover funeral expenses. As the administrator, you must request the necessary form(s) from the funeral home. Be sure that the form(s):

- ☐ Indicates the amount of the benefit assigned and the Funeral Homes tax ID#.
- ☐ Accompanies the funeral home bill and is submitted through the group with the Proof of Death form.
- ☐ Is/are signed by all the named beneficiaries. If only one beneficiary signs the form, proceeds will be deducted from the portion allotted for that beneficiary only.

Note: To assign benefits, the beneficiary must be of legal age; therefore, a minor cannot sign a funeral home assignment. Unimerica Life Insurance Company of New York does not accept collateral assignments (use of life insurance as collateral).

What is Form 712?

Form 712 is a government form required from some beneficiaries for income tax returns. The form includes the amount of money paid on a life claim without interest. This form can be sent upon request.

What if the primary beneficiary is deceased?

If the primary beneficiary is no longer living, a certified death certificate (for the primary beneficiary) must accompany the claim before payment can be made to the contingent (secondary) beneficiary. If the contingent (secondary) beneficiary is also deceased, a certified death certificate will also be required.

What if there is no beneficiary?

Payment may be made to certain relatives or the insured person's estate, as provided in the policy.

Payment to the estate can be made only after court documents of appointment are forwarded to us. The documents of appointment must name the personal representative of the estate (also called the executor, executrix, administrator or similar title) to whom the benefits can be paid and the estate tax ID#.

Payment to a trust can be made when a copy of the trust document is provided with the claim. Such documents must designate a trustee to whom proceeds will be paid and the associated tax ID#.

What if the beneficiary is a minor child?

According to state law, a minor lacks capacity to sign a binding release of an insurance policy. The proceeds can be released to a minor through a lawfully court appointed representative or by any other process allowed under state law. Life insurance benefits, therefore, cannot be paid to anyone who has not reached the age of majority. If court appointed financial guardianship documents or other documents that are approved under state law are not secured, the proceeds will be held by the insurance company bearing interest until the beneficiary reaches the age of majority.

Accelerated Benefit

The accelerated benefit does not apply to all life insurance. Please see your policy to determine whether this feature applies to you.

Who qualifies to receive an Accelerated Benefit?

This benefit allows advance payment of part (based on policy language) of the insured person's life insurance. It may be paid to a person in a lump sum once during his lifetime.

To qualify, the insured person must:

- ☐ Have at least the dollar amount of the life insurance stated in the policy on the date the accelerated benefit is paid. (Check the specific policy for the amount.)
- ☐ Be insured under the policy on the date the accelerated death benefit is to be paid.

How does an insured apply to receive an Accelerated Benefit?

The insured person (or his/her legal representative) must apply for the benefit. To do so, the insured must:

- ☐ Complete a **Notice of Claim - Accelerated Benefit** form.
- ☐ Provide satisfactory proof that the insured person is terminally ill*. Include a physician's written statement indicating the approximate life expectancy.

* Terminally ill is defined as the insured person has a medical condition which is expected to result in death within 12 months, despite appropriate medical treatment. Definitions vary by state laws; please check with your client services administrator.

How much can be withdrawn?

The amount of benefit may be withdrawn in $1,000 increments subject to minimums and maximums defined in the policy (i.e. a minimum of $10,000 or 10%, whichever is greater).

Note: The Accelerated Benefit payment may be taxable to the insured person. This individual should seek assistance from a personal tax advisor regarding taxes that may to be levied as a result of claiming Accelerated Benefits.

Life Insurance Waiver of Premium

The Life Insurance Waiver of Premium does not apply to all life insurance. Please see your policy to determine whether this feature applies to you.

What is a Waiver of Premium?

The Waiver of Premium benefit allows the employee/employer to forego premium payment on life insurance for a totally disabled* employee. The employee is required to provide proof of continued total disability as required by Unimerica Life Insurance Company of New York. After the employee has been totally disabled for two years, proof will be required once a year. Please refer to your policy for the specific reason Waiver of Premium would terminate.

How does an employee apply for a Waiver of Premium?

Complete the **Statement of Continuance of Life Insurance** to make application for these benefits. The employee must be totally disabled as defined by the policy. (See the specific policy for plan details as age and waiting period may vary.) The employer should continue to pay the employee's premium during the waiting period. The covered person must supply proof of claim no later than 12 months after the date he or she becomes "Totally Disabled" in accordance with the policy definition.*

If the employee is covered under Long Term Disability Insurance with Unimerica Life Insurance Company of New York, and has filed a claim for Long Term Disability benefits, it is not necessary to complete the Statement of Continuance of Life Insurance in order to apply for the Life Waiver of Premium benefit. The Life Waiver of Premium benefit will be processed in conjunction with the Long Term Disability claim.

**Note: ***The definition of Total Disability on the Continuance of Life Insurance requires that the employee be unable to perform the duties of their own or any occupation for which he/she may be suited by training, education or experience. Long Term Disability (LTD) language generally requires the employee to be totally disabled from his own occupation initially for a period of time and then from any occupation at the change in definition.

Premium Adjustment

The standard policy provides Waiver of Premium for Life and Voluntary Life. The Accidental Death and Dismemberment (AD&D) policy premium cannot be waived and will terminate upon approval of waiver on the life coverage. Please refer to your specific policy for verification.

List-billed Groups

Unimerica Life Insurance Company of New York Administration area will make adjustments to the billing.

Self-billed Groups

The employer should continue to pay the premium for the employee during the waiting period. The Plan Administrator should make adjustments upon receipt of the Approval for Waiver of Premium, using the effective date indicated.

Portability and Conversion

What are Portability and Employee Conversion?

Portability does not apply to all life insurance. Please see your Group policy to determine whether this feature applies to you.

Portability	**Conversion**
☐ Term life insurance (no cash value) ☐ Age-banded rates increase with current age ☐ Must be insured for three months ☐ Guaranteed full amount when employment terminates for reasons other than disability	☐ Individual whole life insurance (builds a cash value) ☐ Age-banded rates are fixed at the age when conversion insurance is issued ☐ Employee changed insurance to a different policy with much higher premiums ☐ Guaranteed full amount when eligibility ends for reasons other than non-payment of premium. ☐ Spouse and child insurance may also be converted when employee terminates for reason other than disability. ** see certificate plan details.

Portability

Which employees are eligible to port their coverage?

Employees who have purchased basic life and/or supplemental life may be eligible (refer to the Group policy) to port their coverage upon termination of employment provided that they submit their request for portability within 31 days of their termination date.

How do employees request to port their coverage?

The employer and employee must complete the **Request for Portability of Supplemental Group Life Insurance** form.

Employer	Employee
The employer initiates the process by completing the Employer Information sections.	The employee completes all remaining sections of the form, including the calculation of the quarterly or annual premium and applicable charges. Upon completion, the employee forwards the form and initial premium payment to the Unimerica Life Insurance Company of New York address that appears on the form.

What benefit amount are the employees eligible to port?

The employee can port all or a portion of their amount of Life Insurance, however, the ported amount cannot exceed what the insured has at the time they elect to port. (Refer to the Group Policy)

How are employees billed for their coverage?

Upon approval, Unimerica Life Insurance Company of New York will bill the employee directly, based on the payment mode selected.

Note: Refer to your Portability form for the rates.

Life Conversion Privileges

Which employees are eligible to receive conversion privileges?

Be sure to check specific policy to ensure conversion privilege is available.

Employees may convert their coverage if:

- ☐ All or part of their Life Insurance to an individual policy of life insurance, other than term insurance, if their insurance terminated because they ceases to be a member of a class eligible for insurance;
- ☐ The amount of insurance to an individual policy of life insurance, other than term insurance, that is lost due to a reduction of insurance because of age.

Employees may convert a limited amount or insurance to an individual life policy, other than term if:

- ☐ All or part of their insurance terminates due to amendment or termination of the policy, and
- ☐ The employee has been insured continuously under the policy for at least five years.

Any conversion policy issued due to a policy termination or amendment will be subject to the same conditions as a policy issued under the General Conversion Benefit except the amount may not exceed the lesser of:

- ☐ $10,000 (see the specific policy), or
- ☐ The amount of life insurance that terminates is less than the amount of any group life insurance for which the insured person becomes eligible within 31 days after the termination.

Note: If an employee is disabled prior to age 60, he/she should not request conversion, but should be kept on the existing policy until they qualify for Waiver of Premium.

What is a conversion policy?

Employees may purchase an individual life policy, known as a conversion policy, without evidence of insurability. Any policy issued under the General Conversion Benefit will be issued:

- ☐ For an amount not to exceed the amount of the life insurance that was terminated
- ☐ At the insured person's age at nearest birthday
- ☐ Without disability

How can an insured apply for a conversion policy?

The Employer or the Employee can access the conversion portal at www.uhclifeconv.com. The **Individual Life Conversion Request for Information** screen will ask the user to identify as either the Employer or the Employee.

1. Employer: complete the Employer section (Part A) and either print the form or email the form to the Employee for completion of his/her portion.
2. Employee: completes their portion of the online form then either print the form or email the form to the Employer for completion of his/her portion
3. Once both sections are completed, the Employee or Employer can either email the form to conversions@hrmp.com or print the form and mail to:

HRMP
Life Conversion Facility
300 Rosewood Drive, Suite 250
Danvers, MA 01923
(888) 999-4767 Phone
(978) 762-4767 Fax

Is an insured entitled to death benefits during the conversion period?

Unimerica Life Insurance Company of New York will pay a death benefit under the policy equal to the amount of the life insurance which could have been converted, provided the person:

- ☐ Was entitled to purchase a conversion policy, and
- ☐ Dies within the 31-day conversion period.

The death benefit will be paid even if no one applied for the conversion policy. If the first premium was paid for the conversion policy, the premium will be refunded and the conversion policy will be void.

Forms for Life Policies

As the plan administrator, you should be familiar with several forms, including the following:

- ☐ Proof of Death for Group Insurance
- ☐ Statement of Claim for Accidental Dismemberment Benefits
- ☐ Form 712
- ☐ Notice of Claim - Accelerated Benefits
- ☐ Statement of Continuance of Life Insurance
- ☐ Approval for Waiver of Premium Letter
- ☐ Request for Portability of Supplemental Group Life Insurance
- ☐ Individual Life Conversion Request for Information

Short-Term Disability Administration Guidelines

Enrollment

When are employees eligible for short-term disability (STD) insurance?

Employees are eligible for insurance after completing the waiting period. Add all new employees to the bill effective the first of the month following completion of the waiting period or upon signing the Enrollment Form, whichever is later. There will be no mid-month premium calculation.

Employees contractually have 31 days from the effective date to enroll. If employees enroll during this 31-day eligibility period, the effective date will be the first of the month following the date of signature. We strongly suggest that employees complete and submit applications during the waiting period.

Which employees must complete and sign the Evidence of Insurability?

- ☐ **Employer paid (non-contributory) coverage**: no Evidence of Insurability required
- ☐ **Voluntary (contributory) coverage**: Evidence of Insurability required if applicant is applying for an amount over the guaranteed issue amount
- ☐ **Late entrants**: Evidence of Insurability is required

Is there an open enrollment period for voluntary STD?

Yes. There is open enrollment for voluntary plans only. Open enrollment is defined as the time when the plan is initially offered.

- ☐ The only time guarantee issue (GI) amounts are available to current employees is during the open enrollment period.
- ☐ When a new employee is hired, he may apply for insurance. GI is available for new employees during the initial eligibility period.
- ☐ Employees may enroll after the initial open enrollment by completing the Evidence of Insurability form.

Premium

What age should I use to calculate premium?

The employee's age on the eligibility date is used to calculate premium. If a person's age changes from one age band to another, the premium will not increase until the employer's next policy anniversary date or the month following the date of change, depending on the method chosen by the employer group. Please refer to your policy for specifics of your plan.

Taxable Income

If the deductions are made on a post-tax basis, then the benefit is non-taxable to your employees. As such, there will be no matching FICA payments either.

Claim Submission

For assistance regarding Short-Term Disability (STD) claims, please call (866) 556-8298.

How do I submit an STD claim?

Complete the **STD Claim Form**, which includes separate portions for the employer, employee and the physician. To avoid delay in the processing of a claim, be sure to completely answer all questions on the claim form and include a signed authorization.

1. Complete the Employer's portion of the claim form.
2. Ask the employee to complete the Employee portion of the claim form, including having the physician's portion of the form completed. Advise the employee to submit as much information as possible.
3. Submit all pages of the claims form (original copy is not required):

FAX completed forms to: OR (888) 555-8550 **EMAIL** completed form to: fpcustomersupport@uhc.com	**MAIL** completed forms to: Unimerica Life Insurance Company of New York Disability P.O. Box 7466 Portland, ME 04112-7466

When will a decision be made regarding disability benefits?

The Claim Department will make an initial decision within 5 working days upon receipt of a completed claim or upon receipt of the completed claim forms. This initial decision will either:

- ☐ Approve benefits and issue a check to the claimant
- ☐ Pend the claim for additional information
- ☐ Deny the claim if the claim is not eligible for payment

Additional information may be needed from the attending physician, employer or claimant and could impact the analysis necessary to make the initial decision. Upon receipt of the additional requirements, the claims department will review the new information within 5 working days.

To be eligible for benefits a person must be found totally disabled according to the terms of our policy. Total disability must last for a fixed period of time, most often throughout the Elimination Period, after which s/he may be partially disabled as further explained on the next page. Total disability means the employee is unable to perform all of the material and substantial duties of his regular occupation due to sickness or injury and has a 20% or more loss in his indexed pre-disability weekly earnings. Each claim must be reviewed.
Benefits are not guaranteed even if the doctor indicates total disability on the claim form. Benefits are paid based upon evidence submitted that supports a total disability status and not solely based upon a physician's opinion.

The supporting medical documentation, such as office and treatment records (i.e. test results, x-rays) must support the policy definition of totally disabled. Office and treatment records created by a physician following each visit are considered to be objective documentation.

What guidelines are used to help determine the duration of a disability?

The Medical Disability Advisor is a set of guidelines developed by a respected independent physician, Dr. Presley Reed working with a team of accredited experts. These guidelines are one of the tools used by the disability staff to outline expectations for the length of disability for a specific diagnosis or procedure. Several factors are taken into account when applying the guidelines such as occupation, age, and variability with a diagnosis.

How is a state disability plan taken into account?

Most employers in the state of New York are required to provide state-mandated disability income insurance (the state TDI plan) for both full-time and part-time employees. The amount received through the state TDI plan would be deducted from the claimant's benefit.

How are work related disabilities handled?

The standard policy excludes any work related conditions. A disability claim filed on the basis of a work-related injury may be excluded under the policy. If UnitedHealthcare is asked to reconsider the claim, the employee will be asked to provide a copy of the Workers' Compensation denial.

Are pre-existing conditions excluded?

Disabilities caused by, or contributed to by, a pre-existing condition are excluded from insurance under the policy unless certain conditions have been met. A pre-existing condition applies to a sickness or injury including mental illness, substance abuse or subjective symptoms for which the insured person, within a specified time prior to the Effective Date of insurance, was diagnosed by or received treatment from a legally qualified physician; or had symptoms for which an ordinarily prudent person would have sought treatment.

Are maternity claims eligible for STD benefits?

Our standard policy treats maternity the same as any other illness.

NOTE: Pregnancy, like other medical conditions, may be subject to the pre-existing limitation shown in the Plan Documents.

Benefit Payment

To who are checks paid?

Employers who self fund claims can have checks sent to them for distribution to their employees. Fully insured clients checks are sent directly to the employee.

Are employees on Salary Continuance eligible for STD benefits?

Salary continuance is considered to be any money paid by the employer to the employee excluding vacation time or any money earned by the employee. Since salary continuance may be either included or excluded as an offset to benefits, based on employer selection under the standard Short-term Disability policy, any monies deemed as salary continuance provided to an employee may make them ineligible for benefits or reduce their benefit. The employee may receive salary continuance during the elimination period.

Note: Elimination Period is the length of time the Insured Person must be continuously disabled before a benefit is payable.

What are Partial Disability benefits?

Partial Disability provides benefits to an employee who returns to work on a part-time basis. Partial Disability Benefit equals the lesser of one of the following:

- ☐ The insured person's basic weekly earnings multiplied by the benefit percentage (limited to the maximum weekly benefit)
- ☐ The insured person's basic weekly earnings minus earnings received from any form of employment for that period of disability

The benefit percentage, maximum weekly benefit and definition of basic weekly earnings are shown in the Schedule of Benefits.

Example #1	Example #2
Pre-Disability Earnings $300.00 Benefit Percentage 60% Maximum $150.00 Part-time Earnings $220.00 1. $300.00 x .60 = $180.00 2. $300.00 - $220.00 = $80.00 The lesser is #2, $80.00. This is the amount the claimant would receive.	Pre-Disability Earnings $200.00 Benefit Percentage 66 2/3% Maximum $90.00 Part-time Earnings $150.00 1. $200.00 x .6667 = 133.34 2. $200 - 150.00 = $50.00 The lesser is #2, $50.00. This is the amount the claimant would receive.

How can denial of claims be appealed?

The claimant has 180 days to appeal a denial. The appeal must be in writing and must provide specific information outlining why the employee disagreed with our original decision. Please attach supporting documentation.

Send a written appeal to:	Unimerica Life Insurance Company of New York Disability P.O. Box 7466 Portland, ME 04112-7466
Email written appeal to:	fpcustomersupport@uhc.com
FAX written appeal to:	(888) 505-8550

The company has 45 days to respond to an appeal with the possibility of two 30-day extensions due to circumstances beyond our control.

Forms for STD Policies

- ☐ Statement of Insurability
- ☐ STD Claim Form

Long-Term Disability Administration Guidelines

Enrollment

When are employees eligible for long-term disability (LTD) insurance?

Employees are eligible for insurance after completing the waiting period. Add all new employees to the bill effective the first of the month following completion of the waiting period or upon signing the **Enrollment Form**, whichever is later. There will be no mid-month premium calculation.

Employees contractually have 31 days from the effective date to enroll. If employees enroll during this 31-day eligibility period, the effective date will be the first of the month following the date of signature. We strongly suggest that employees complete and submit applications during the waiting period.

Which employees must complete and sign the Statement of Insurability?

- ☐ **Employer paid (non-contributory) coverage:** no Statement of Insurability required
- ☐ **Voluntary (contributory) coverage**: Statement of Insurability required if applicant is applying for an amount over the guaranteed issue amount
- ☐ **Late entrants**: Statement of Insurability is required. If a Statement of Insurability is required, the insurance becomes effective the later of the date he/she just became eligible or on the date the statement of insurability is approved by Unimerica Life Insurance Company of New York.

Is there an open enrollment period for LTD?

There is open enrollment for voluntary plans only. Open enrollment is defined as the time when the plan is initially offered.

- ☐ The only time guarantee issue (GI) amounts are available to current employees is during the open enrollment period.
- ☐ The new employee may apply for insurance at time of hire. GI is available for new employees during the initial eligibility period.

- ☐ Employees may enroll after the initial open enrollment by completing the Statement of Insurability form.

Premium

What age should I use to calculate premium?

The employee's age on the eligibility date is used to calculate premium. If a person's age changes from one age band to another, the premium will not increase until the employer's next policy anniversary date or the month following the date of change, depending on the method chosen by the employer group. Please refer to your policy for specifics of your plan.

Taxable Income

If the deductions are made on a post-tax basis, then the benefit is non-taxable to your employees. As such, there will be no matching FICA payments either.

Claim Submission

For assistance regarding Long Term Disability (LTD) claims, please call **(888) 299-2070**.

How do I submit an LTD claim?

The claim should be submitted half way through the elimination period to ensure a decision is made before the first payment is due (if the claim is payable).

Complete the LTD Claim Form, which includes separate portions for the employer, employee and the physician. To avoid delay in the processing of a claim, be sure you completely answer all questions on the Claim Form and include a signed authorization.

- ☐ Complete the Employer's portion of the Claim Form
- ☐ Ask the employee to complete the Employee portion of the Claim Form, including having the physician's portion of the form completed. Advise the employee to submit as much information as possible.
- ☐ Submit all pages of the claim form (original copy is not required)

Send the completed claim form to Unimerica Life Insurance Company of New York for processing:

FAX completed forms to: (888) 505-8550 **EMAIL** completed forms to: fpcustomersupport@uhc.com	**Mail** completed forms to: Unimerica Life Insurance Company of New York Disability P.O. Box 7466 Portland, ME 04112-7466

Note: Claims should be submitted as soon as the employee believes that the disability will last as long as the elimination period. For tracking purposes, it is preferable to receive a claim during the elimination period rather than have to obtain medical information retroactively after the

elimination period has been satisfied. Advise the employee to submit as much medical information as possible.

Waiver of Premium

How do I apply for waiver of premium?

Long-Term Disability insurance includes waiver of premium. This is an automatic benefit once the claim is approved, provided the disability extends beyond the period required to qualify. The employee and employer will receive a notification from the claims area indicating, "Your waiver of premium is effective _ (date)."

The premiums will be adjusted:

For List-billed Groups	For Self-billed Groups
Unimerica Life Insurance Company of New York Administration area will be notified of the waiver and will adjust the bill.	The plan administrator must make the adjustment upon receipt of the copy of the approval letter and use the effective date indicated on the correspondence. The employer should not make the adjustment until notified that the claim has been approved for waiver of premium.

Approval of Benefits

When will a decision be made regarding disability benefits?

The claim will be reviewed within 5 working days of receipt and an initial decision will be made to either:

- ☐ Approve benefits and issue a check to the claimant
- ☐ Pend the claim for additional information
- ☐ Deny the claim if the claim is not eligible for payment

An initial phone call to the employee and employer will be made during the 5-day period.

What is the elimination period?

The elimination period is the length of time the employee must be continuously disabled before a benefit is payable. No benefits are payable for that period.

What is accumulation of elimination period?

Accumulation of the elimination period wording allows for the temporary recovery during the elimination period and is designed to reward a covered employee's attempt to return to work. It ensures that:

- ☐ Disabled employees are not penalized for trying to go back to work during the elimination period.
- ☐ The days the employee is not disabled will not count toward satisfying the elimination period.
- ☐ The days an employee is not disabled may be consecutive or intermittent.
- ☐ All or part of the elimination period can be completed while working if the covered employee is considered disabled under the terms of our policy during the period of work activity.

Are pre-existing conditions excluded?

Disabilities caused by, or contributed to by, a pre-existing condition are excluded from insurance under the policy unless certain conditions have been met. A pre-existing condition applies to a sickness or injury including mental illness, substance abuse or subjective symptoms for which the insured person, within a specified time prior to the Effective Date of insurance, was diagnosed by or received treatment from a legally qualified physician; or had symptoms for which an ordinarily prudent person would have sought treatment.

What if the employer changes carriers?

LTD insurance has a Continuity of Insurance upon transfer of insurance carrier's provision to ensure that employees insured under a policy will not lose insurance due to a change in carriers. Continuity of Insurance applies to the traditional policy provisions such as the:

- ☐ Active at work requirement, and
- ☐ Pre-existing condition exclusion

In order to provide Continuity of Insurance, we must have a copy of the prior carrier's policy, certificate of insurance or plan booklet. If Continuity of Insurance is a state mandated regulation, we must receive a copy of the prior policy, etc. before issuing the policy.

Benefit Payment

How is the benefit payment calculated?

The policy dictates the percent of benefit (some policies provide for a flat benefit amount) that the employee is entitled to receive. The Schedule of Benefits page in the policy specifies:

- ☐ The benefit amount or percentage of benefit
- ☐ The percentage is multiplied by the pre-disability income of the employee.
- ☐ The policy also contains a minimum and maximum benefit amount available under the policy.

Some common reasons for differences in the amount paid versus amount expected on disability claims are:

- ☐ Unreported salary increase
- ☐ Length of the payment period
- ☐ Taxes
- ☐ Integration of other income

When is the benefit paid?

The initial payment, when appropriate, is made when a decision is rendered on a claim. If the period for payment has passed, payment is released to a current date. If the employee has a 30-day elimination period, payment will not usually be released until the period for which payment is to be made has passed.

Example:

If the elimination period is from 09/01 to 10/01, payment is made for the benefit payment period from 10/01 to 11/01. This payment will usually be sent approximately 7 days prior to November 1.

Payment will not be made beyond the date the physician has released the employee without supporting documentation. If a claim is submitted indicating a release date prior to the current date, payment will not be made beyond that date. Checks are sent directly to the employee.

How does a change in salary impact LTD benefit check amounts?

If the claim was incurred prior to the date of increase, the increase would not be reflected in the benefit. If the increase was effective prior to the date of disability or death and meets policy requirements for reporting salary increase, you must provide the amount and date of the increase and pay back premium on the increased amount. After receipt of the premium for the increased amount, the adjustment to the benefit will be made and any retroactive benefits due would be paid to the employee.

How do I submit information for a part-time employee receiving disability?

Provide the number of hours the employee works each day and the rate of pay. Provide this information on either a weekly or monthly basis by submitting an Earnings Statement.

Are work-related disabilities covered?

Work related disabilities are insured, however, our standard policy integrates with Workers' Compensation benefits. We deduct the Workers' compensation benefit from the total employee benefit.

Example:

Employee's benefit	$1,000 per month
Employee received from Worker's Comp	- 300 per month
Net Disability Benefit from LTD	$ 700 per month

Maximum Benefit Period

Please see your policy for your plan's specific provisions regarding LTD Maximum Benefit Periods.

Reducing Benefit Duration (RBD)

This approach provides a graded benefit period for disabilities commencing on or after age 60. Also referred to as "To Age 65 Reducing Benefit Duration," it is one of the most common maximum benefit periods. Please see your policy for the specific benefit duration for your plan.

Social Security Normal Retirement Age (SSNRA)

The SSNRA benefit period schedule adapts the RBD schedule by including a simple statement incorporating the Social Security Normal Retirement Age. The Insured Person's normal retirement age under the Social Security Act depends on the year of birth. Please see your policy for the specific benefit period for your plan.

Will Unimerica Life Insurance Company of New York honor court orders for garnishment of disability benefits?

Yes, Unimerica Life Insurance Company of New York will honor court orders for garnishments if a claimant is receiving a disability benefit from our Company. In order to do this, we will accept one of the following:

- ☐ A written request from the employer with a copy of the court order for garnishment of disability benefits, or
- ☐ A copy of the court order if it is sent directly from the court or from any other entity.

The request must be made in writing and submitted to the claims specialist handling the claim.

Must employees file a new claim for a recurrent disability?

The employee who has attempted to return to full-time work for six months or less will be considered the same claim, provided it is for the same disabling condition as the first period of disability. An employee who has returned to work for more than six months must file a new claim. If the employee returns to work, even if for a period less than six months and becomes disabled with a new disabling condition, it will be handled as a new claim.

How can denial of claims be appealed?

In order to appeal a denied claim, the employee must submit a written appeal indicating the reason the claim should be reconsidered, which must be received within 180 days from the date of the denial.

If the denial was due to a waiting period or effective date issue, proof will be required to support the employee's position. Appropriate proof would be an Enrollment Form or copies of payroll deductions. The employee should also provide additional information to support the appeal such as medical records, test results or payroll records.
A written response will be completed within 45 days advising the claimant if additional information is needed or if a decision has been reached. If additional time is needed, the employee will receive a letter outlining the reason for the delay. The appeal determination should not take longer than 90 days.

Send a written appeal to:

Unimerica Life Insurance Company of New York

P.O. Box 7466

Portland, ME 04112-7466

FAX – (800) 980-0298 EMAIL – fpcustomersupport@uhc.com

What is needed to notify Unimerica Life Insurance Company of New York that the employee has returned to work?

The following information is required and may be provided via telephone call:

- ☐ Date the employee returned to work
- ☐ If the employee did not return to the prior occupation, provide a job description with physical demands for the new position, as well as payroll records.

A doctor's release form must be faxed or mailed to Unimerica Life Insurance Company of New York.

FAX completed forms to: OR (888) 555-8550 **EMAIL** completed forms to: fpcustomersupport@uhc.com	**MAIL** completed forms to: Unimerica Life Insurance Company of New York Disability P.O. Box 7466 Portland, ME 04112-7466

LTD Portability Provision

This is an optional benefit. Please check you contract to determine if your coverage includes Portability.

Which employees are eligible to port their coverage?

Employees are eligible to port their coverage upon termination of employment provided that they submit their Request for Portability within 31 days of their termination date.

How do employees request to port their coverage?

The employer and employee must complete the Request for Portability Long-Term Disability form.

Employer	Employee
The employer initiates the process by completing the Employer Information section (A and B).	The employee completes all remaining sections (C, D and E), including the calculation of the quarterly or annual premium and applicable charges. Upon completion, the employee sends the form and initial premium payment to the Unimerica Life Insurance Company of New York address that appears on the form.

How are employees billed for their coverage?

Upon approval, Unimerica Life Insurance Company of New York will bill the employee directly, based on the payment mode selected.

Forms for LTD Policies

As the plan administrator, you should be familiar with several forms, including the following:

- ☐ Enrollment Form
- ☐ Statement of Insurability
- ☐ LTD Claim Forms and Instructions for Group Long-Term Disability

Rehabilitation Services Administration Guidelines

What are Rehabilitation Services?

We partner with local independent agencies to provide rehabilitation benefits to assist the claimant in returning to the previous work site or to seek alternative work sites. We provide, free of charge, professional case managers (Vocational Counselors and Registered Nurse Case Managers) to assist claimants. These professionals are certified and experienced in the management of long-term and short-term disability cases.

Our Company provides this service at our cost and we are billed directly by the rehabilitation service. Vendors are selected by contacting national companies experienced in this business and local contacts that have performed excellent services in the past.

Who uses Rehabilitation Services?

Rehabilitation candidates are selected using criterion that indicates the person will benefit from Rehabilitation Services. These criteria include the following:

- ☐ Age (usually below 55)
- ☐ Motivated and interested in rehabilitation services
- ☐ In need of retraining or "hands on" assistance
- ☐ Stable physical condition that would not prevent work in other occupations
- ☐ Liability over the life of the claim outweighs cost of services (if person is at a minimum monthly benefit it would be too costly to provide rehabilitation services)

Example of a Rehabilitation Case:

A teacher had a psychological problem and was unable to return to work as a teacher. He received benefits for a few years and after this amount of time, his psychological condition stabilized. His physician released him to return to employment as long as it was not in his previous occupation. We initiated rehabilitation services and a vocational counselor met with him over the course of a few months. The counselor spoke with the physician and claimant, tested the claimant, explored community resources, assisted the claimant in writing his resume, practiced a job interview, and facilitated the job search. As a result, the claimant now has a new full time job where he is very satisfied.

Early Return to Work

Our Company can provide excellent partial benefit plans to help facilitate an employee returning to work. Accommodation funds are also available if the claimant should need special equipment or accommodation.

Contact is made with the employer to communicate a release to return to work and the restrictions that have been assigned by the physician. Our Company is staffed with Registered Nurse Case Managers and Vocational Coordinators who coordinate "Return to Work" efforts between the claimant, employer and the physician.

UnitedHealth Allies Administration Guidelines

Enrollment

Ongoing Enrollment

How do I submit ongoing enrollments?

Your company can use one of two methods to submit ongoing enrollment data to UnitedHealth Allies:

- ☐ Continuing with the **electronic enrollment process** – This process simply continues the enrollment process utilized in the initial enrollment. Your company will establish a scheduled timeframe with UnitedHealth Allies to send updated employee information for new hires, termination, and updated employee information (such as name or address changes.) This process is detailed in the Customer Update Process document.
- ☐ Moving to a **manual enrollment process** – This process may be more suitable if your company cannot maintain a process for sending electronic census to UnitedHealth Allies beyond the initial enrollment.

This process is determined in the Group Application/Agreement.

How do I add employees?

The manual process requires your company's Benefit Administrator to manually add each new employee through the UnitedHealth Allies website using the following steps:

1. Log onto www.HealthAllies.com and select "Create Account."
2. Select "No, I have not received my membership card," then select "But I have a Group ID number."
3. Enter your company's Group ID to begin the online enrollment process.
4. Enter all the employee information.
5. Assign each enrolled employee a user name and password. The suggested user name is "firstname.lastname" or a similar simple format (e.g. "john.smith" or "jsmith") and password "password1."
6. Inform each employee of the user name and password you assigned. The employee can change the password using the 'My Account' tool.

Your Group ID will be provided by UnitedHealth Allies if the Manual Enrollment process is selected in the Group Application/Agreement.

How do I update employee information?

If your organization follows the manual enrollment process, employees can log on to the website (www.HealthAllies.com) and update their own information (name, address, spouse, dependents, etc.) in the "My Account" section of the website. Or, they can speak with a Customer Service Representative at (800) 377-0263 to change the information.

How do I remove an employee who has been terminated?

If your organization follows the manual enrollment process, notify UnitedHealth Allies of termination by sending an email to Client-Support@HealthAllies.com. Be sure to include your company's name and the complete name of the employee who is to be terminated. The benefit for the employee will terminate at midnight of the last day of the month in which UnitedHealth Allies is notified of the termination. (UnitedHealth Allies does not do retroactive termination.)

How do I enroll late applicants?

Because UnitedHealth Allies program is not an insurance program, members can be enrolled at any time. Membership becomes effective immediately either when the data is loaded (electronic enrollment process) or when the Benefits Administrator adds the employee (manual enrollment process.)

Who is considered to be a rehired employee?

Any employee who returns to work after temporary termination may re-enroll in the UnitedHealth Allies program.

How do I enroll a rehired employee?

- ☐ Complete a new Enrollment Form and include the rehire date and current information. Rehires are treated as "ADDS" on the next month's eligibility file.
- ☐ Re-enrollees will receive new membership cards and member numbers unless the same employee/customer ID is submitted to UnitedHealth Allies in the eligibility file (electronic enrollment process only).

Membership Kits

Am I responsible for distributing and maintaining membership cards?

No. HealthAllies sends Membership kits, which include the membership card(s) and Welcome Brochure to employees' homes.

Can members order replacement cards?

Yes. Members can order replacements for lost/stolen cards or additional cards for dependents that are away at school in either of the following ways:

- ☐ Call the HealthAllies Customer Service Center at (800) 377-0263.
- ☐ Log onto www.HealthAllies.com and order cards using the "My Account" tool.

Enrollment Checklist

You are required to obtain a completed **Enrollment Form** for each employee or group member enrolled in the program, whether offered on a contributory or non-contributory basis. These forms are for the Employer's records and are a substitution for the file required by UnitedHealth Allies to update eligibility. File the completed Enrollment Form with your office records.

Do not fax or mail the enrollment forms to Unimerica Life Insurance Company of New York or to HealthAllies.

Please use this checklist as a guide when collecting enrollment information.

- ☐ Review Enrollment Form for legible, complete and accurate information. Be sure the employee or group member has signed and dated the form.
- ☐ Be sure required spouse and dependent information has been provided (Health Value Program offers family membership).
- ☐ Be sure the employee or group member has provided a daytime phone number(s) so that HealthAllies can confirm provider selections.
- ☐ If the Health Value Program is offered on a contributory basis, be sure the employee or group member has signed the payroll deduction authorization.

Forms for Health Value Program

These forms/documents are pertinent for administering the Unimerica Life Insurance Company of New York Health Value Program.

- ☐ UnitedHealth Allies Group Agreement and Application Client Agreement and Group Application
- ☐ Enrollment Form
- ☐ Customer Update Process document

Specified Disease Plan Administration Guidelines

What is the Specified Disease Plan Product?

The Specified Disease Plan is an indemnity type product which provides a lump-sum benefit in each of 3 benefit categories to an insured upon a confirming diagnosis of any one of 13 critical illnesses. The money can be used for any expense to protect your employees' quality of life while critically ill. This product is available for employer groups with at least 51 employees and is available on an employer-paid, employee paid (voluntary) or employer-paid base/voluntary buy up basis.

What conditions are covered under this product?

There are three benefit categories under this product, covering the following conditions:

- ❑ Category 1
  - Level 1: Invasive Cancer
  - Level 2: Non-invasive Cancer*
  - Level 3: Non-invasive skin cancer, not covered under Level 2
- ❑ *Category 2
  - Myocardial Infarction (Heart Attack, Heart Transplant, Coronary Artery Bypass*)
  - Ruptured Aneurysm
  - Stroke
- ❑ Category 3
  - Chronic Renal Failure

**Partial benefit*

Is there an individual underwriting requirement for this product?

No, the Specified Disease product is sold as guaranteed issue only.

What are the requirements for late entrants?

A late entrant is a term used on plans where the employees enroll for coverage and contribute to the premium. An employee has 31 days from their initial eligibility date to sign up for coverage. If they do not sign up during this initial 30 day period, and later request to sign up for benefits, they are considered to be a late enrollee. An employee who is a late enrollee can elect coverage during a subsequent annual/re-enrollment period.

Who falls into the category of late entrant?

A late entrant is a term used on plans where the employees enroll for coverage and contribute to the premium. An employee has 31 days from their initial eligibility date to sign up for coverage. If they do not sign up during this initial 30 day period, and later request to sign up for benefits, they are considered to be a late enrollee.

Is the Specified Disease Plan List-billed or Self-billed?

The Specified Disease Plan can be either List-billed or Self-billed. Refer to the appropriate section of this manual for specific procedures for each billing type.

Eligibility

Employees are eligible for coverage. Dependent coverage is optional at the policyholder level. All dependents are covered for the same conditions as the employees.

Claims Submission

How do I submit a claim?

1. Be sure employee has completed the Claim form and Instructions for Critical Illness Protection Plan in full.
2. The employee should attach copies of any supporting medical records they have to validate the claim. Direct employees to refer to Certificate of Coverage for the definition that applies to each critical illness and ask their physicians to provide information in support of that definition.
3. The employee should complete the Employee's Authorization for Release of Information to allow Unimerica Life Insurance Company of New York of New York to secure additional information if necessary, to make a decision on the claim for benefits. Instruct employees to also provide a copy of the form to their physician(s).
4. Claims submissions must include:
    - ☐ Employer's Statement
    - ☐ Employee's Specified Disease Statement supporting documentation
    - ☐ Employee's Authorization for Release of Information

FAX forms to: OR (888) 505-8550 Phone: (888) 505-8550 EMAIL – fpcustomersupport@uhc.com	**MAIL** completed forms to: Unimerica Life Insurance Company of New York P.O. Box 7466 Portland, ME 04112-7466
Note: Instruct physicians to respond to any requests for information by sending requested records to the address above.	

Optional Benefits

(Check your policy for the specifics on your plan)

Are employees eligible to port their coverage?

If you have purchased portability, employees who have purchased Specified Disease insurance coverage are eligible to extend their coverage for 12 months upon termination of employment provided that they submit their **Request for Portability** within 31 days of their termination date.

Is a Wellness Benefit available?

Yes. If you have purchased this benefit, insured's can be paid up to $100 per calendar year for specified health screening tests. Insured must provide adequate proof of having had a contract-specified health screening test performed.

Employees must complete and submit the **Group Specified Disease Wellness Benefit Claim Form** to the address listed on the form with a copy of the invoice for the screening test they are requesting reimbursement for.

Is an Occupational HIV Benefit available?

Yes. If the Occupational HIV benefit is included on the policy.

We will pay the Occupational HIV Benefit shown on the Schedule of Benefits in a lump sum for exposure to the Human Immunodeficiency Virus (HIV) if:

1. A Covered Person, who elected coverage under the benefi is included within the Eligible SIC Codes shown below, sustains an Injury in the performance of his or her occupational duties; and
2. As a result of such Injury, the Covered Person acquires and tests positive for HIV. Eligible SIC Codes:

1. 801x-804x Physicians and Dentists
2. 805x-906x Hospitals, Nursing Facilities
3. 807x-809x Medical/Dental Labs, Clinics, Home Health Care, other health Services
4. 922x Police/Fire/Corrections

Forms for the Specified Disease Plan

As the plan administrator, you should be familiar with several forms, including the following:

- ☐ Verification for Specified Disease Coverage
- ☐ Authorization for the Release of Information (HIPAA) Request for Portability of Specified Disease

- ☐ Group Specified Disease Insurance Health Screening Benefit Claim Form
- ☐ Specified Disease Enrollment Form
- ☐ Specified Disease Claim Form
- ☐ Certificate of Coverage

Accident Protection Plan Administration Guidelines

What is Accident Protection?

Accident Protection Plan is an indemnity product providing financial protection for expenses related to injuries due to a covered accident. Payments are based on the amounts shown in the schedule of benefits. Benefit payments are paid directly to the insured to use at their discretion. This product is available for employer groups with at least 51 employees and is available on an employer-paid, employee paid(voluntary) or employer-paid base/buy up basis.

What conditions are covered under this product?

The Accident Protection Plan offers coverage for accidental death and dismemberment, initial care, hospital care, follow-up care and covered injuries and services. Our plans cover things like emergency room visits, fractures, dislocations, x-rays and rehabilitation. Refer to your benefit summary for coverage details, as plan designs may vary.

Is there an underwriting requirement for this product?

There is no underwriting required for this product.

What are the requirements for late entrants?

A late entrant is a term used on plans where the employees enroll for coverage and contribute to the premium. An employee has 31 days from his or her initial eligibility date to sign up for coverage. If he or she does not sign up during this initial 30-day period, and later requests to sign up for benefits, he or she is considered to be a late enrollee. An employee who is a late enrollee can elect coverage during a subsequent annual/re-enrollment period.

Is the Accident Protection Plan List-billed or Self-billed?

The Accident Protection Plan Product can be List-billed or Self-billed. Refer to the appropriate section of this manual for specific procedures for each billing type.

Eligibility

Employees are eligible for coverage. Dependent coverage is optional at the policyholder level. Dependent coverage must match the Employee level coverage.

Claims Submission

How do I submit a claim?

1. Be sure employee has completed the Accident Protection Plan claim form. The claim form is available on eAdministration/eBill.
2. Employee should attach copies of any supporting medical records they have to validate the claim. Direct employees to refer to the Certificate of Coverage and the schedule of benefits for the covered conditions. Ask their physicians to provide information in support of that condition.
3. Employee should complete the Employee's Authorization for Release of Information to allow Unimerica Life Insurance Company of New York of New York to secure additional information if necessary, to make a decision on the claim for benefits. Instruct employees to also provide a copy of the form to their physician(s).
4. Claims submissions must include:
   - ☐ Employee's Statement
   - ☐ Completed Claim Form
   - ☐ Supporting documentation
   - ☐ Employee's Authorization for Release of Information

FAX completed forms to: OR (888) 505-8550 EMAIL – fpcustomersupport@uhc.com	**MAIL** completed forms to: Unimerica Life Insurance Company of New York P.O. Box 7466 Portland, ME 04112-7466 Phone: (866) 556-8298
Note: Instruct physicians to respond to any requests for information by sending requested records to the address above.	

Optional Benefits

(Check your policy for the specifics on your plan)

Are employees eligible to port their coverage?

Portability is included in the Accident Protection Plan. Employees who have purchased Accident Protection Plan Coverage are eligible to extend their coverage upon termination of employment provided that they submit their **Request for Portability** and pay first month's premium within 31 days of their termination date.

Is a Wellness Benefit available?

Yes.

If you have purchased this benefit, insured's will be paid accordingly to their selected plan level/schedule of benefits. Insured must provide adequate proof of having had a contract- specified health screening test performed. Refer to your Certificate of Coverage for a list of covered tests. The insured refers to the covered employee and covered spouse. This benefit is not available for children.

Employees must complete and submit the **Wellness Benefit Claim Form** to the address listed on the form with a copy of the invoice for the screening test they are requesting reimbursement for.

Forms for the Accident Protection Plan

As the plan administrator, you should be familiar with several forms, including the following:

- ☐ Statement of Insurability – Group Accident Protection Plan Insurance
- ☐ Authorization for the Release of Information (HIPAA)
- ☐ Request for Portability
- ☐ Wellness Benefit Claim Form
- ☐ Accident Protection Plan Enrollment Form
- ☐ Accident Protection Plan Claim Form
- ☐ Your company's Certificate of Coverage

Hospital Indemnity Plan Product Administration Guidelines

What is Hospital Indemnity Protection Plan?

Hospital Indemnity Protection Plan is an indemnity product that pays cash directly to you. The money can be used anyway you choose: it can be saved, used for hospital expenses, related treatments, health plan deductibles or other out-of-pocket expenses.

What are the benefits under this product?

Base Plan benefits include:

- Hospital admission
- Hospital confinement
- Intensive Care Unit (ICU) confinement

Base + Enhanced Plan benefits include:

- Hospital admission
- Hospital confinement
- Intensive Care Unit (ICU) confinement
- ICU admission
- Emergency Room
- Lodging
- Transportation

Benefits may vary by state, please see your Certificate of Coverage.

Is there a medical underwriting requirement for this product?

No medical underwriting is required for Hospital Indemnity.

What are the requirements for late entrants?

A late entrant is a term used on plans where the employees enroll for coverage and contribute to the premium. An employee has 31 days from his or her initial eligibility date to sign up for coverage. If he or she does not sign up during this initial 30-day period, and later requests to sign up for benefits, he or she is considered to be a late enrollee. An employee who is a late enrollee can elect coverage during his or her subsequent annual/re-enrollment period.

Is the Hospital Indemnity Protection Plan list-billed or self-billed?

The Hospital Indemnity Protection Plan Product can be either list-billed or self-billed. Refer to the appropriate section of this manual for specific procedures for each billing type.

Eligibility

All full, time active employees working the required minimum hours per week (see your Certificate of Coverage for required hours). Employees are eligible for coverage; dependent coverage is optional at the policyholder level. Dependent coverage cannot exceed that of the employee's.

Claims Submission

How do I submit a claim?

1. Be sure employee has completed the Claim Form and Instructions for Hospital Indemnity Protection Plan in full.
2. Employee should attach copies of any supporting medical records he or she has to validate the claim. Direct employees to refer to the Certificate of Coverage for the definition that applies to each benefit and ask their physicians to provide information in support of that definition.
3. Employee should complete the Employee's Authorization for Release of Information to allow UnitedHealthcare to secure additional information if necessary, to make a decision on the claim for benefits.
4. Instruct employees to also provide a copy of the form to their physician(s).
5. Claims submissions must include:
   - Employer's Statement
   - Employee's Statement
   - Supporting Documentation
   - Employee's Authorization for Release of Information

FAX completed forms to:
(800) 980-0298
Phone: (888) 299-2070

EMAIL completed forms to:
fpcustomersupport@uhc.com

MAIL completed forms to:
UnitedHealthcare
P.O.Box 7466
Portland, ME 04112-7466

Note: Instruct physicians to respond to any requests for information by sending requested records to address above.

Optional Benefits

(Check your policy for the specifics on your plan)

Are employees eligible to port their coverage?

Portability is included in the Hospital Indemnity Protection Plan. Employees who have purchased Hospital Indemnity Protection Plan Coverage are eligible to extend their coverage for 12 months upon termination of employment provided that they submit their **Request for Portability** within 31 days of their termination date.

Is a Wellness Benefit available?

Yes, if this benefit is included in your plan. Insureds will be paid the designated benefits amount (see your Certificate of Coverage for amount) once per calendar year for specific health

screening tests. Insured must provide adequate proof of having had a contract-specific health screening test performed. The insured refers to the covered employee and covered spouse. This benefit is not available for children.

Employees must complete and submit the **Group Hospital Indemnity Protection Plan Insurance Wellness Benefit Claim Form** to the address listed on the form with a copy of the invoice for the screening test they are requesting reimbursement for.

Forms for the Hospital Indemnity Plan Product

As the plan administrator, you should be familiar with several forms, including the following:

- Certificate of Coverage.
- Authorization for the Release of Information (HIPAA)
- Request for Portability.
- Hospital Indemnity Enrollment Form.
- Hospital Indemnity Claim Form.
- Hospital Indemnity Wellness Claim Form.

FMLA & Leave Administration Guidelines

Submitting a Leave Request

Unimerica Life Insurance Company of New York is committed to supporting your employees during their absence and helping them achieve a timely and healthy return to work. We have prepared a guide titled *Requesting a Family Medical Leave or Short-term Disability Claim* for employees. This guide is available by calling Unimerica Life Insurance Company of New York or by downloading the form from the eAdministration site. This guide will assist an employee in submitting a request for scheduled or unscheduled absences. This process applies to short-term disability (STD), the Family Medical Leave Act, and related state or company specific leave policies.

Follow these simple steps

1. The employee should notify their supervisor or manager of their absence from work.
2. Using the Information Checklist, employees should gather information about their absence and have this information ready when they call us. If someone makes the call for them (e.g. a family member), he or she will need to provide this information on their behalf.
3. Call us toll free at 1-866-556-8298. Hours of operation are Monday through Friday, 8:00 a.m. – 6:00 p.m. ET.
4. If the employee's absence from work is due to their health condition, s/he will sign and date an Authorization Form. This form is provided to the physician. The employee should also fax a copy of the signed, dated form to us at **1-888-505-8550**

What Happens Next

Every absence is unique and next steps can differ depending upon the type of claim or leave request. When the employee contacts us at **1-866-556-8298** and we learn more about their specific request, we will guide them through the process, answer any questions and tell them what to expect next. They have our commitment to be responsive and supportive during their time away from work.

Information Checklist

The employee should have the following information ready when they call:

- ☐ Employer's name and location
- ☐ Employee's full name and Social Security number
- ☐ Employee's complete address and phone number
- ☐ Date of birth
- ☐ Marital status and number of dependents
- ☐ Occupation or job title
- ☐ Supervisor's name and phone number
- ☐ Last day worked and first day they were absent from work
- ☐ Date they expect to return to work (if they know), or the actual date (if they have already returned to work at the
- ☐ time of call)
- ☐ If the absence or claim is due to their own health condition, please have the following information available:
    - Description of medical condition, including any relevant dates of injury or if it is work related
    - Physician's name, address and phone number
    - Dates of their first visit, their most recent visit, and their next scheduled visit with their physician for this condition