


Oxford Verification Form

Please complete and provide the following document along with the Certification Form and tax documentation requested. Please submit all documents through IDEA and do not submit such documents directly to Risk Management unless you receive communication requesting additional information.

Group Name:	Group Number: PW15339	Renewal Date: 3/1/2018
Email Address:	Phone Number:	Federal Employer Identification Number (EIN):

1. Does the business have any full-time eligible employees other than the owner and owner's spouse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is your group a Professional Employer Organization (PEO), Employee Leasing Company (ELC), or other such entity that is a co-employer, with your client(s), of client-site employees? *If yes, then by signing this form, you agree with the following certification: I hereby certify that my company is a PEO, ELC, or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. I understand that UnitedHealthcare will not cover the co-employees under this group policy.	<input type="checkbox"/> Yes* <input type="checkbox"/> No

Common Ownership

Please list all companies that are eligible to be included as part of a consolidated federal tax return (even if they don't file a consolidated federal tax return) or who are part of a controlled group as defined under the Internal Revenue Code.

Business Name	Federal Tax ID #	# of Full time Employees	On this Policy
1. _____	_____	_____	Yes / No
2. _____	_____	_____	Yes / No
3. _____	_____	_____	Yes / No
4. _____	_____	_____	Yes / No

Please check one of the following:

I certify that my business applying for coverage with UnitedHealthcare is not part of a controlled group (commonly owned or affiliates) as defined under the Internal Revenue Code.

Or

I certify that my business(es) applying for coverage with UnitedHealthcare (1) is eligible to file a consolidated federal tax return or (2) meets the IRS test for being a controlled group under common control. I further certify there are no other affiliated entities, other than the ones listed above, who are part of the controlled group that includes my business.

I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I agree to notify UnitedHealthcare in the event of a change in any of the information that is the subject of this certification. I understand that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

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