DELTA DENTAL

CoPower ONE™
GROUP DENTAL APPLICATION

Delta Dental of New York, Inc.
150 East 58th Street, 24th Floor
New York, NY 10155
800-471-7091

APPLICANT INFORMATION				
Name of Applicant:		Fed. ID/TIN:		
Contact:		Phone:		
Email:		Fax:		
Address:				
City:		State:	Zip Code:	County:
Industry Type:		SIC:		
Billing Address, if different:				
Billing Contact:		Phone:		Fax:
Billing Email:				
Situs State: New York	Group Type: Employer	Contact Type: Non Retention		Length of Contract: 1 year
Proposed Effective Date:				
Recipient of Electronic Documents and Notices: ☐ Applicant ☐ Other (provide name and email, address, or fax number):				
I, the Contract holder, authorize the broker to manage eligibility on my behalf: ☐ Yes ☐ No				
Name of prior dental carrier:				

DELTA DENTAL PPO™ BENEFIT DESIGNS – Underwritten by Delta Dental of New York			
	GOOD	**BETTER/BETTER PLUS**	**BEST**
Select a Dental PPO plan	**PPO:** ☐ $1,000 Delta Dental PPO **Minimum Participation Based:** ☐ MPB $1,500 Delta Dental PPO ☐ MPB $1,500 Delta Dental PPO + Ortho	**PPO (Better):** ☐ $1,500 Delta Dental PPO + Ortho **PPO Plus Premier (Better Plus):** ☐ $1,500 Delta Dental PPO Plus Premier + Ortho	**PPO Plus Premier:** ☐ $2,000 Delta Dental PPO Plus Premier + Ortho

DeltaCare® USA BENEFIT DESIGNS – Underwritten by Delta Dental of New York
Select a DeltaCare USA plan ☐ 13B

DELTA DENTAL'S DUAL CHOICE BENEFIT DESIGNS

☐ Dual Choice – Choose any one Delta Dental PPO plan (except MPB plans) and the DeltaCare USA 13B plan from above

☐ Dual Choice MPB – Choose any one Delta Dental PPO MPB plan (MPB or MPB with ortho) and the DeltaCare USA 13B plan from above.

CONTRIBUTION AND PARTICIPATION

PPO Employer Contribution and Participation Requirement (check one):

☐ 100% All eligible employees ☐ 75%-99.9% 75% of eligible employees ☐ 50%-74.9% (groups 51-99) 75% of eligible employees ☐ 0%-49.9% (groups 51-99) or 0-74.9% (groups 2-50)

For groups with 5 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 5 primary enrollees. For groups with 2-4 eligible enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.

DeltaCare USA Employer Contribution Requirement (check one):

☐ At least 75% for employees and dependents ☐ At least 75% of employees ☐ Less than 75% of employees

Enrollment may not be less than 2 primary enrollees.

Rates and Enrollment				**Second Plan if Dual Choice is Selected**			
	Monthly Rates	#Primary Enrollees	Total		Monthly Rates	#Primary Enrollees	Total
3 Tier							
EE Only	$	x	= $	EE Only	$	x	= $
EE+1	$	x	= $	EE+1	$	x	= $
EE+2 or more	$	x	= $	EE+2 or more	$	x	= $
TOTAL: $				**TOTAL:** $			

ELIGIBILITY INFORMATION

Census Date (fill in the total # of primary employees for each of the applicable boxes, listed below):

# of Eligible Employees:

PPO*	**DeltaCare***
# of Enrolled Employees:	# of Enrolled Employees:

Eligible Individuals (check applicable boxes): ☑ Eligible Employees ☐ Retired Employees:

Eligible Dependents (check applicable boxes): ☑ Spouse ☑ children ☐ Domestic Partner ☐ Others

Eligible Requirement (check one): ☐ Date of hire ☐ First of the month following date of hire ☐ First of the month following _____ days of employment

*If electing Dual Choice populate both PPO and DeltaCare enrolled employee fields.

Application is herewith made for a dental insurance contract from Delta Dental of New York (Delta Dental). It is understood that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the plan. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta Dental's designated administrator and accepted by the administrator on behalf for Delta Dental, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered as an inducement for issuance of a dental insurance contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant.

This plan shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility list will be submitted to Delta Dental's designated administrator by the 25th of the month prior to the coverage month.***

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta Dental's designated administrator with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental plan as described in the group dental insurance regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental insurance contract to be executed between the Applicant and Delta Dental. ***Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.***

Executed this _____ day of _____ 20____, for the Applicant at _____
(City and State)

By : _____ Signature: _____
(Print Name and Title)

Delta Dental Authorized Signature: _____
Michael G Hankinson, Esq., EVP, Chief Legal Officer

BROKER/AGENT INFORMATION

Broker/Agent Name:		State License:	
National Producer Number:			
Contract Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? ☐ Yes ☐ No	
Commission Mailing Address:	City:	State:	Zip:
Commission(s):	Payable to:		
Broker/Agent Signature: _____		Date: _____	

ELECTRONIC DELIVERY OF DOCUMENTS TERMS AND CONDITIONS

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your Dental contract-related documents made available to you electronically. If you choose to have your contract-related documents made available to you electronically, the terms & conditions below apply.

1. Communication Methods: All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental or Delta Dental's designated administrator website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.
2. Types of Documents that Will Be Electronically Communicated: Documents available electronically include, but are not limited to: your contract, the Evidence of Coverage (Certificate/EOC) for your enrollees and your notifications.
3. How to Withdraw Consent: You may withdraw your consent to transact business electronically by contacting Delta Dental's designated administrator. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic Communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.
4. How to Update Your Records: It is your responsibility to provide us with true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information by contacting Delta Dental's designated administrator.
5. Hardware and Software Requirements: In order to access, view, sign and retain electronic documents that we make available to you, you must:
    - Have a device that will connect to the Internet, access to an email account and access to an internet browser.
    - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
    - Be able to view the disclosures on your device.
    - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.

☐ **Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents provided electronically.**

Delta Dental Administrator's Use ONLY

Application accepted on: _____

Delta Dental PPO Group #: _____ TPA Employer #: _____

DeltaCare USA Group #: _____ TPA Employer #: _____

CoPower *ONE* VSP Program (New York)

Group Information		CoPower communications is by electronic mail.
Company Name:		DBA:
Street Address:		
City:	State:	Zip:
Billing Address (*if different*):		
City:	State:	Zip:
Contact Name:		Title:
Email:	Phone:	Fax:
If you wish to opt out of Email communication, check this box ☐		SIC Code (*required*):
Type of Business:	Tax ID #:	Date Business Established:

Employer is a: ☐ Partnership ☐ Corporation ☐ Sole Proprietorship ☐ Public Agency ☐ Other (please explain):	Requested Effective Date:	HR360 Enrollment ☐ Yes ☐ No *(Free Online HR Support)*

Vision Service Plan (2-1000)		
Total # of Employees:	Total # of Eligible Employees:	Total # of Enrolling Employees:
Employer Contribution	Employee: _____ *(100% for all plans except voluntary)*	Dependent: _____ *(minimum 0%)*
Prior Carrier: _____ ☐ None	☐ CoPower ONE Good Choice Plan A 12/24/24 ☐ CoPower ONE BEST Choice Plan A 12/12/12 ☐ CoPower ONE Vol Choice Enhanced B 12/12/12	
Cancel Date: _____	☐ CoPower ONE Better Enhanced Plan B 12/12/24	

Group Eligibility Information / Carve-Out / COBRA	
Is the new hire waiting period waived for initial enrollments? ☐ Yes ☐ No Eligibility begins on the first of the month following: ☐ Date of Hire ☐ 1 Mo. ☐ 2 Mo. ☐ 3 Mo. Days: _____ Other: _____	Is this group a class carve-out? ☐ Yes ☐ No If yes, state the class of employees to be covered: Is your group currently subject to Fed-COBRA ☐ Yes ☐ No **Fed-COBRA:** *Employed 20+ eligible employees on at least 50% of its working days in the previous calendar year** **Visit www.dol.gov for more COBRA eligibility information.*

Administrative Fee Policy – Charged monthly
$15 – VSP (2-4 Groups receive a 1 year discounted rate of $10

Invoices If you wish to opt out of E-mail invoices, check this box
Contact Name _____Email address _____
The above information will be used to authenticate access to the invoice. You must notify CoPower if this contact or e-mail address changes.

Initial Payment Do you wish to have your initial payment debited from your company account?

- ☐ Yes – Please complete the bank information below and enter the premium amount
- ☐ No – Please submit a company check made payable to CoPower.

Ongoing Payment Do you wish to have your monthly invoice amount automatically debited from your company account?

- ☐ Yes – Please complete the bank information below. *(Allow up to one billing cycle to process your request. You must continue to submit your payment until your invoice indicates that the amount due will be debited from your account.)*
- ☐ No

Bank Account Information *(must be a Checking Account)*
Account Holder's Name (if different from above): _____
Name of Bank: _____
Bank Address: _____
Bank Routing Number: _____ Account Number: _____
Prem Amount – Number (e.g. $50): $ _____ Prem Amount – Written (e.g. fifty dollars) _____ dollars

I hereby authorize CoPower to initiate debits from the account identified above. I understand it remains in effect until I give written notice to CoPower, which I must do by the 25th of the month prior to the month coverage. If I want to change the banking information that CoPower debits, I will submit a new Direct Debit Authorization form by the 25th of the month prior to the month of coverage. In the event a debit is made to my account in error, I authorize CoPower to make a correcting entry to my account. CoPower will notify me of payments returned for insufficient funds or close accounts, and repayment instructions.

Employer Signature

My Signature on this document certifies that all of the information contained in this application is true and correct to the best of my knowledge. I confirm that all enrollees are eligible employees, COBRA participants, and/or their dependents. In addition, my group complies with all the rules and regulations as set forth by the applicable carrier(s).

Signature of Company Officer: _____ Date: _____

Name (print): Title (print):

Producer Statement

(Must be completed for commissions. Producers (agent or agency) must have a signed Producer Agreement with CoPower).

Producer Signature:	Producer Signature:
Producer Name (print):	Producer Name (print):
Federal Tax ID or SSN:	Federal Tax ID or SSN:
Company Name:	Company Name:
Address:	Address:
City:	City:
State: Zip: Date:	State: Zip: Date:
Telephone: Fax:	Telephone: Fax:
Email:	Email:
Make commissions payable to: ☐ Producer ☐ Agency	Make commissions payable to: ☐ Producer ☐ Agency
Multiple producer split? ☐ Yes ☐ No	Multiple producer split? ☐ Yes ☐ No
Percentage of split: %	Percentage of split: %

First Unum Life Insurance Company

APPLICATION FOR GROUP INSURANCE
First Unum Life Insurance Company
2211 Congress Street ▪ Portland, Maine 04122

Name of Applicant _____

Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip)

Applies to the First Unum Life Insurance Company, for:

- ☐ Group Life Benefits
- ☐ Group Accidental Death and Dismemberment Benefits
- ☐ Group Specified Disease Benefits
- ☐ Group Cancer Benefits
- ☐ Group Hospital Confinement Indemnity Benefits
- ☐ Group Short Term Disability Benefits
- ☐ Group Long Term Disability Benefits
- ☐ Group Accident Benefits (This is a limited benefit plan and does not provide comprehensive hospital, surgical, or medical coverage).

Policy Effective Date: _____

Is there medical insurance in force for employees: ☐ Yes ☐ No

Policyholder confirms and understands that a Group Accident Benefits Policy provides accident only coverage and does not provide hospital, surgical or medical coverage. ☐ Yes ☐ No

Policyholder confirms and understands that a Group Hospital Confinement Indemnity Policy is a supplement to health insurance and is not a substitute for major medical coverage or other minimum essential coverage. ☐ Yes ☐ No

Is there any group life insurance plan in force or being applied for on some or all employees? ☐ Yes ☐ No
If yes, compete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates	Termination Dates

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. The policy specifications will be made a part of the policy along with a copy of this form.

By signing this Group Master Application, you acknowledge that you have received a copy of Unum's Disclosure Notice.

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

Signed at ____NOT REQUIRED_____ _____
(City and State) (Applicant)

On _____ By: _____ _____
(mm/dd/yyyy) (Signature and Title)

Broker Name: _____ Broker Signature: _____

SS# / Tax ID# (last 4 digits): _____

GROUP MASTER APPLICATION COMPENSATION DISCLOSURE INSERT

Your insurance or benefits advisor can offer you advice and guidance as you select the policy and provider most appropriate for your needs. At Unum we recognize the important role these professionals play in the sale of our products and services and offer them a variety of compensation programs. Your advisor can provide you with information about these programs as well as those available from other providers. We support disclosure of broker compensation so that customers can make an informed buying decision.

Brokers may be eligible to receive Base Commissions as well as Supplemental Commissions from Unum.

Unless you have agreed in writing to compensate the broker differently, Unum provides Base Commissions to all brokers in connection with the sale of an insurance policy. Base Commissions are a fixed percentage of the policy premium, and may include a one time, first year, flat amount for each policy sold. Base Commissions are paid by Unum to the broker(s) on your policy. In some circumstances, broker(s) may be eligible to receive commissions on your policy even after a broker of record change has occurred.

A broker may also qualify for Supplemental Commissions paid by Unum. For group insurance products, Supplemental Commissions may be paid as a fixed percentage of total eligible group insurance premiums. The Supplemental Commission rate depends on the total dollar amount of all eligible premiums or number of group policies that the broker had in force with Unum in the prior calendar year. The Supplemental Commission rate may range from 0% to 13.80% of total premiums paid.

Supplemental Commissions may be calculated differently for other insurance products. The premium you pay is not impacted whether or not your broker receives Supplemental Commissions.

Your broker may partner with other insurance specialists (i.e. Broker General Agents) to provide additional support in the product selection, plan design, quotes, and on-going servicing of your policy. Unum compensates these Broker General Agents for their Services.

If you would like additional information about the range of compensation programs our company offers for your group insurance policy or any other Unum insurance product, you can find more details at www.unum.com. Should you have other questions not addressed by the website, including the Supplemental Commission percentage applicable to your broker, or if you want to speak to us directly about broker compensation, please call 1-800-ASK-UNUM (1-800-275-8686).

1052-05 NY (01/16)

UNUM EMPLOYEES COMPENSATION DISCLOSURE STATEMENT

This notice is provided to you pursuant to New York Regulation 194 regarding transparency of producer compensation. At Unum we recognize and support full transparency and disclosure of compensation.

Certain Unum employees are licensed by the state of New York as insurance producers. Licensed Unum employees represent and act on behalf of Unum. Unum compensates some licensed employees based on the sale of insurance policy or policies. Such compensation may vary depending on a number of factors, including the type of insurance policy a purchaser selects. In some cases, other factors, such as volume of business or achievement of certain sales or persistency goals, also may affect compensation payable to a licensed Unum employee.

In those instances where a Unum Enrollment Representative is involved: Unum Enrollment Representatives are licensed as insurance producers; they represent and act on behalf of Unum. Enrollment Representatives do not receive compensation based solely on the sale of insurance to you.

If you would like to request information about compensation expected to be received by licensed Unum employee(s) that is based in whole or in part on the sale of insurance to you, contact us at Field Compensation (207) 575-6573 or email NYRegulation194Inquiries@Unum.com.

Unum is providing this notice on behalf of the following insuring companies: First Unum Life Insurance Company (NY) and Provident Life and Casualty Insurance Company (NY).

SD-1081-NY (12/13)