CoPower *ONE* Employer Application

CO power
An Amwins Company

Group Information – CoPower communication 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 E-mail communications, 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:
Prior Dental Carrier: ☐ None	Dental Cancel Date:	Zywave HR 360 Enrollment *(Free Online HR Support):* ☐ Yes ☐ No
Prior Life Carrier: ☐ None	Life Cancel Date:	

Group Eligibility Information

Total # of Employees:	Total # of Eligible Employees:	Total # of Enrolling Employees:

Is the new hire waiting period waived for initial enrollments? ☐ Yes ☐ No

Eligibility begins on the first month following:
Date of Hire ☐ 1 Mos. ☐ 2 Mos. ☐ 3 Mos.
Days: Other:

Is this group a class carveout? ☐ Yes ☐ No

If yes, state the class of employees to be covered:

(For Delta Dental, employees not covered by Delta PPO plans must enroll in DeltaCare USA plans or be left uninsured. Carve outs will be classified as level 2 regardless of true industry SIC)

Domestic Partners allowed to enroll? ☐ Yes ☐ No

Children of Domestic Partners able to enroll? ☐ Yes ☐ No

Is your group currently subject to: ☐ COBRA ☐ Fed-COBRA

- Cal-COBRA: *Employed 2-19 eligible employees**
- Fed-COBRA: *Employed 20+ eligible employees**

**For at least 50% of working days in the previous calendar year, Visit www.dol.gov for more COBRA eligibility information.*

Does the company have a pre-tax Sec. 125 or POP Plan? ☐ Yes ☐ No

Do you elect Open Enrollment for your CoPower ONE plan?
(Group must have pre-tax Sec. 125 or POP plan in place) ☐ Yes ☐ No

Employer Contribution:
Employee = (minimum 75%; for voluntary plans maximum 74%)
Dependent = (minimum 0%)

CoPower *ONE* Package Information

Dual choice dental option (PPO/HMO), Enhanced Life Option, and LTD are available to non-voluntary groups with 10+ enrolling employees. Enhanced 35K Life Option available for 2+ enrolling employees.

☐ Bronze (2-99) ☐ Silver (5-99) ☐ Gold Premier (5-99) ☐ Platinum Premier (5-99) Plan Type (choose one): ☐ PPO ☐ HMO ☐ Dual Choice

☐ Voluntary PPO (5-99)* ☐ Voluntary HMO (2-99)* ☐ Dual Choice Voluntary PPO/HMO (10+)**
☐ Voluntary PPO Ortho Option (25-99 only)*

**Voluntary plans include dental & vision only*
***A minimum of 5 enrolled in each plan*

Waive wait at initial enrollment with proof of prior comprehensive dental coverage & final bill. ☐ Yes ☐ No

In order to maintain enrollment in the plans included in the CoPower ONE program, you must continue coverage in all lines of benefits. Delta Dental PPO and Delta Dental PPO Plus Premier are underwritten by Delta Dental of California, VSP Choice is underwritten by Vision Service Plan, and Unum is underwritten by Unum Life Insurance Company of America. These companies are financially responsible for their own products. Life Beneficiary forms should be held and maintained by employer.

Optional Benefits: Unum Enhanced Life, Voluntary Life, and LTD (Not part of the CoPower ONE bundle).

Unum Enhanced Life Option: ☐ $35K ☐ $50K ☐ $100K ☐ $150K

*Select one to replace the standard life amount and sign the Unum application on **page 3**. Additional premium rates apply.*

Unum Voluntary Option: ☐ Yes ☐ No

*If yes, please check and sign the Group Lifestyle Protection Accidental Death and Dismemberment Benefits box on **page 3.** Each employee or spouse applying must submit the Unum Voluntary Life app.*

Unum Group Long Term Disability Option *Please complete and sign the Application for Group Insurance – LTD on **page 4.***

Select Elimination Period: ☐ 90 day ☐ 180 day ☐ 360 day Healthcare Protect Ride: ☐ $300 ☐ $500 ☐ $1,000 ☐ None

Optional Benefits: Landmark Chiropractic & Acupuncture (2-199) *(Not part of the CoPower ONE bundle)*

Total # of Enrolling Employees: _____	Employer Contribution	Employee: _____ *(min. 50%)*		Dependent: _____ *(min. 0%)*
Medical Carve-out? *(Minimum 5 Enrolled)* If yes, choose one: ☐ HMO ☐ PPO	Plan Type: ☐ Chiro Only ☐ Chiro + Acu	Product Category: ☐ Standard ☐ Expanded	Office Copay: ☐ $10 *(51+ EE only)* ☐ $15 ☐ $20	Visits: ☐ 20 ☐ 30 *(51+ EE only)*

Payment/Invoice - CoPower communication is by electronic mail

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 and attach a copy of a voided check. ***(****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: _____

Premium Amount – Number (e.g. $50): $ _____

Premium 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)

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

Producer Statement (must be completed for commissions)

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

APPLICATION FOR PARTICIPATION IN THE SELECT GROUP INSURANCE TRUST
Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

To: The Trustees of The Select Group Insurance Trust and Unum Life Insurance Company of America

Name of Employer/Applicant _____

Address: _____

_____
(City) (State) (Zip)

requests approval to participate in the above named Group Insurance Trust and that

- ☑ Group Life Benefits
- ☐ Group Lifestyle Protection Life Benefits
- ☐ Group Universal Life Benefits
- ☑ Group Accidental Death & Dismemberment Benefits
- ☐ Group Lifestyle Protection Accidental Death & Dismemberment Benefits
- ☐ Group Short Term Disability Benefits
- ☐ Group Long Term Disability Benefits
- ☐ Group Long Term Care Benefits

be made available to its eligible employees under the terms of the Policy(ies) issued to the Trustee(s) of the Trust. The effective date of this insurance coverage is to be _____ or such other date as the Insurance Company approves, whichever is later. If this request is approved, no insurance for which evidence of insurability is required will become effective until approved by the Insurance Company at its Home Office.

Is there any group life insurance plan in force or being applied for on some or all employees? ☐ Yes ☐ No

If yes, complete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates (mm/dd/yyyy)	Termination Dates (mm/dd/yyyy)

By this application, the Employer/Applicant agrees and accepts the terms of the Trust Agreement for the Trust named above for so long as it elects to participate in the Trust. This includes all amendments to the Trust Agreement and any Rules and Regulations adopted by the Trustee(s) under the same Agreement.

The Employer/Applicant authorizes the Trustee(s) to act as its agent for the purposes set forth in the Trust Agreement. This includes functions relevant to the administration of Group Insurance; including but not limited to: (1) collection of premiums; (2) holding insurance policy(ies); and (3) delegation of agency to insurers. The Employer/Applicant also: (1) agrees to remit regularly the required premium payments; and (2) elects coverage as shown in the Summary of Benefits.

The Employer/Applicant acknowledges that the group policy(ies) under which insurance is provided contain(s) numerous optional provisions which are available in order to provide each employer with the ability to select provisions which meet its own needs. It is understood and agreed that only those provisions which appear in the Summary of Benefits provided to the Employer/Applicant apply to its insurance coverage.

Only approval of this request in writing by the Trustees shall permit the employer/applicant to participate in the above Trust. Insurance will become effective upon approval of the Insurance Company at its Home Office.

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

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

Producer Name: CoPower Administrators, Inc. Producer Signature: _____
(Please Print)

SS# / Tax ID#: 32-0052349 State ID #: CA Policy Effective Date: _____
(mm/dd/yyyy)

PRODUCER INFORMATION: For Commission purposes, please list the producers for this application. Use full names, including complete business names. To ensure proper payment of commissions, include each producer's tax identification number (social security number or corporate tax id) and state identification number where applicable. If more than one producer, please be sure to specify the split %. For corporate producers, please specify the signing representative's name and ID #'s.

PLEASE PRINT ALL INFORMATION CLEARLY

	Producer Name (Please print full name)	SS# / Tax ID#	State ID# (where applicable)	Split % age (Must total 100%)	Unum Producer # (If known)
1.	CoPower Administrators, Inc.	32-0052349	CA	100%	570620
2.					
3.					

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

APPLICATION FOR GROUP INSURANCE - LTD
Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

Name of Applicant _____

Address: _____
(Street)

_____
(City) (State) (Zip)

applies to the Unum Life Insurance Company of America, for:

- ❑ Group Life Benefits
- ❑ Group Accidental Death and Dismemberment Benefits
- ❑ Group Critical Illness Benefits
- ❑ Group Cancer Benefits
- ❑ Group Short Term Disability Benefits
- ❑ Group Worksite Short Term Disability Benefits
- ☑ Group Long Term Disability Benefits
- ❑ Group Long Term Care Benefits
  - ❑ Tax Qualified* ❑ Non-Tax Qualified**
  - ❑ Nursing Home Insurance
  - ❑ Comprehensive Insurance
- ❑ Group Accident Benefits

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

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates (mm/dd/yyyy)	Termination Dates (mm/dd/yyyy)

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.

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

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

Broker Name: CoPower Administrators, Inc. Broker Signature: _____
(Please Print)

SS# / Tax ID# (last 4 digits): 2349 Policy Effective Date: _____
(mm/dd/yyyy)

*The contract for Long-Term Care Insurance is intended to be a federally qualified Long-Term Care Insurance contract and may qualify for Federal and State tax benefits.

**The contract for Long-Term Care Insurance is not intended to be a federally qualified Long-Term Care Insurance contract.

AE-1080-CA