

# CoPower ONE Employer Application

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 Public Agency	Corporation Sole Proprietorship 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: <i>(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)</i> 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* <i>*For at least 50% of working days in the previous calendar year, Visit <a href="http://www.dol.gov">www.dol.gov</a> for more COBRA eligibility information.</i> 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) are available. Enhanced Life Options 50K, 100K or 150K are available for 10+ enrolling employees. Enhanced 35K Life option and LTD are available for 2+ enrolling employees.			
Bronze	Silver	Gold Premier	Platinum Premier
Plan Type (choose one):		PPO	HMO
Voluntary PPO (5-99)*		Voluntary HMO (2-99)*	Dual Choice Voluntary PPO/HMO (10+)**
Voluntary PPO Ortho Option (25-99 only)*		Waive wait at initial enrollment with proof of prior comprehensive dental coverage & final bill. Yes No	
*Voluntary plans include dental & vision only			
**A minimum of 5 enrolled in each plan			

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 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 Add-ons: Unum Enhanced Life, Voluntary Life, and LTD.

<b>Unum Enhanced Life Option:</b> \$35K \$50K \$100K \$150K Select one to replace the standard life amount and sign the Unum application on <b>page 3</b> . Additional premium rates apply.	<b>Unum Voluntary Option:</b> Yes No If yes, please check and sign the Group Lifestyle Protection Accidental Death and Dismemberment Benefits box on <b>page 3</b> . Each employee or spouse applying must submit the Unum Voluntary Life app.
<b>Unum Group Long Term Disability Option</b> Please complete and sign the Application for Group Insurance – LTD on <b>page 4</b> (HP Rider for 10-Life+ plans only). 2-Life+ 10-Life+90EP 10-Life+180EP 10-Life+360EP Healthcare Protect Rider: \$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: <input type="checkbox"/> HMO <input type="checkbox"/> PPO	Plan Type: <input type="checkbox"/> Chiro Only <input type="checkbox"/> Chiro + Acu	Product Category: <input type="checkbox"/> Standard <input type="checkbox"/> Expanded	Office Copay: <input type="checkbox"/> \$10 (51+ EE only) <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 Visits: <input type="checkbox"/> 20 <input type="checkbox"/> 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 Signature:		
Producer's Name (print):			Producer's 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:
E-mail:			E-mail:		
Make commissions payable to: <input type="checkbox"/> Producer <input type="checkbox"/> Agency			Make commissions payable to: <input type="checkbox"/> Producer <input type="checkbox"/> Agency		
Multiple producer split: <input type="checkbox"/> Yes <input type="checkbox"/> No		Percentage of split: %	Multiple producer split: <input type="checkbox"/> Yes <input type="checkbox"/> 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

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Group Life Benefits           | <input checked="" type="checkbox"/> Group Accidental Death & Dismemberment Benefits           | <input type="checkbox"/> Group Short Term Disability Benefits |
| <input type="checkbox"/> Group Lifestyle Protection Life Benefits | <input type="checkbox"/> Group Lifestyle Protection Accidental Death & Dismemberment Benefits | <input type="checkbox"/> Group Long Term Disability Benefits  |
| <input type="checkbox"/> Group Universal Life Benefits            |   | <input type="checkbox"/> 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.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

461-84 (6/98)

(07/08)



**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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Group Life Benefits                                  | <input type="checkbox"/> Group Cancer Benefits                          | <input type="checkbox"/> Group Long Term Care Benefits                               |
| <input type="checkbox"/> Group Accidental Death<br>and Dismemberment Benefits | <input type="checkbox"/> Group Short Term Disability Benefits           | <input type="checkbox"/> Tax Qualified* <input type="checkbox"/> Non-Tax Qualified** |
| <input type="checkbox"/> Group Critical Illness Benefits                      | <input type="checkbox"/> Group Worksite Short Term Disability Benefits  | <input type="checkbox"/> Nursing Home Insurance                                      |
|   | <input checked="" type="checkbox"/> Group Long Term Disability Benefits | <input type="checkbox"/> Comprehensive Insurance                                     |
|   |   | <input type="checkbox"/> 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.

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