Application for Delta Dental of California Small Business Program, Delta Dental Choice, VSP, Unum and Landmark plans.

This application may be used for groups enrolling in a plan for:

- Delta Dental of California Small Business Program
- Delta Dental Choice
- VSP
- Unum
- Landmark

For complete program guidelines please refer to the applicable CoPower *SELECT* Summary of Benefits and Rate Guide.

Follow the guidelines below to complete this application based on the plan(s) in which your group is enrolling.

For Delta Dental of California Small Business Program only - Complete Delta Dental SBP Group Dental application on pages 1 through 3 **AND** the Group Eligibility Information/Carve-out/COBRA, Payment/Invoice, and Producer Statement sections on page 5.

For Delta Dental Choice, VSP, Unum, and Landmark - Complete only the CoPower *SELECT* portion of the application on pages 4 through 7.

For Delta Dental of California Small Business Program AND another *SELECT* plan - Complete all three pages of Delta SBP portion in full, plus the applicable CoPower *SELECT* portions.

For Multiple Producer Splits - Complete the Broker/Agent Information section on page 3 **AND** the Producer Statement on the CoPower *SELECT* section on page 5.

Submission Guidelines

□ Submit a company check made payable to CoPower, or refer to page 5 for electronic payment options.
□ List of employees, social security numbers, dates of birth, mailing addresses, and dependent information (name, gender and date of birth) on the appropriate CoPower *SELECT* Census Enrollment Form.
  - Enrolling employees may also complete the CoPower Employee Enrollment/Change Form–All Plans.

□ For Delta Dental:
  - Completed waivers and declination of coverage documents for employees waiving due to other dental coverage. Waivers not required for Voluntary plans.

□ For Delta Dental:
  - DE-9C quarterly wage statement—reconciled or one month payroll register.

□ For Delta Dental Voluntary Plan
  - If the group has prior comprehensive dental and wish to waive the benefits waiting period for initial enrollees, please provide the latest invoice and Prior Plan Summary.

□ For VSP Non-voluntary plans with 9 or less enrolled employees:
  - DE-9C quarterly wage statement—reconciled or one month payroll register.
  - DE-9C is not required for: VSP voluntary plans, Unum, and Landmark

□ For Life: A Unum Employee Beneficiary Designation Form—to be provided to the employer for their records.
□ For Voluntary Life and AD&D:
  - A completed Unum Employee Voluntary Term Life and AD&D Enrollment Form.
  - A completed Evidence of Insurability Form (for coverage amounts above the Guaranteed Issue limits).
  - Please check the Group Life Benefits box on the “Basic Term Life” form. (page 6).

□ For Unum LTD:
  - Complete “Application for Group Insurance – LTD” if enrolling in LTD (page 7).

□ For Landmark:
  - Provide group’s current medical bill.
  - For carve-out groups: designate medical plan type, and provide bill showing all enrollees on the designated plan.

SMALL BUSINESS PROGRAM
GROUP DENTAL APPLICATION

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
415-972-8300

APPLICANT INFORMATION			
Name of Applicant:		Fed. ID/TIN:	Public Entity: ☐ Yes ☐ No
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: California	Group Type: Employer	Contract 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 California				
	CORE		**ADVANTAGE**	**DELUXE**
Select a Dental PPO plan	**PPO:** ☐ /2Ŝ нлл	**PPO:** ☐ /2Ŝ млл	**PPO:** ☐ !ŘØl·yůl·ƎŜ плл **PPO Plus Premier™:** ☐ !ŘØl·yůl·ƎŜ олл ☐ !ŘØl·yůl·ƎŜ нлл ☐ !ŘØl·yůl·ƎŜ млл	**PPO:** ☐ 5ŜƒǳȄŜ олл **PPO Plus Premier:** ☐ 5ŜƒǳȄŜ нлл ☐ 5ŜƒǳȄŜ млл
/l·fŜyŘl· ¸Ŝl· a l·Ȅʎ϶ǳ϶ ό tŜ 9y2ffŜŜύ	☐ ÞмΣллл	☐ ÞмΣллл ☐ ÞмΣрлл	☐ ÞмΣллл ☐ ÞмΣрлл ☐ ÞнΣллл ☐ ÞнΣрлл	☐ ÞмΣрлл ☐ ÞнΣллл ☐ ÞнΣрлл ☐ ÞоΣллл
Orthodontic Services (Optional)			☐ No ☐ Child Only	☐ No ☐ Child Only ☐ Adult & Child
Orthodontic Lifetime Maximum (Per Enrollee)			☐ $1,000 ☐ $1,500	☐ $1,500
D&P Maximum Waiver®			☐ Yes ☐ No	

DELTACARE® USA BENEFIT DESIGNS – Underwritten by Delta Dental of California			
	CORE	**ADVANTAGE**	**DELUXE**
Select a DeltaCare USA plan	☐ 17B	☐ 15B	☐ 11A

DELTA DENTAL'S DUAL CHOICE BENEFIT DESIGNS			
☐ Dual Choice 1 - Choose any one Delta Dental PPO plan and any one DeltaCare USA plan from above			
☐ Dual Choice 2	**D&P Maximum Waiver** ☐ Yes ☐ No	**Orthodontic Services (Optional)** ☐ No ☐ Child Only	**Calendar Year Maximum (Per Enrollee)** ☐ $1,500 ☐ $2,000
☐ Dual Choice 3	**D&P Maximum Waiver** ☐ Yes ☐ No	**Orthodontic Services (Optional)** ☐ No ☐ Child Only	**Calendar Year Maximum (Per Enrollee)** ☐ $1,000 Low/$1,500 High ☐ $1,500 Low/$2,500 High
☐ Core/Buy-Up	**Fee Basis (select one)** ☐ PPO ☐ PPO Plus Premier	**Orthodontic Services (Optional)** ☐ No ☐ Child Only	**Calendar Year Maximum (Per Enrollee)** ☐ $1,000 Core/$1,500 Buy-Up ☐ $1,000 Core/$2,000 Buy-Up

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% 50% of eligible employees	☐ 0%-49.9% (Voluntary Plan Only)

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% for employees	☐ Less than 75% for employees

Enrollment may not be less than 2 primary enrollees.

PPO Core/Buy-Up Employer Contribution* and Participation Requirement (check one):

☐ 100% All eligible employees	☐ 75%-99.9% 75% of eligible employees	☐ 50%-74.9% 50% of eligible employees

Enrollment, in both the Core and Buy-Up options, may not be less than the greater of the percentage listed above or five primary enrollees.

* Employer contribution is based solely on the Core rates.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

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	= $
4 Tier							
EE Only	$	x	= $	EE Only	$	x	= $
EE+Spouse	$	x	= $	EE+Spouse	$	x	= $
EE+Child(ren)	$	x	= $	EE+Child(ren)	$	x	= $
EE+Family	$	x	= $	EE+Family	$	x	= $
		TOTAL	$			**TOTAL**	$

ELIGIBILITY INFORMATION

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

# of Eligible Employees:

PPO*	**DeltaCare***	**Dual Choice PPO**
# of Enrolled Employees:	# of Enrolled Employees:	# of Enrolled Employees (Low/Core/PPO Plus Premier): # of Enrolled Employees (High/Buy-Up/PPO):

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 1 populate both PPO and DeltaCare enrolled employee fields.

Application is herewith made for a dental service contract from Delta Dental of California (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 and accepted by Delta Dental or its designated administrator(s), 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 service 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 they have read the statements and responses above and that to the best of their knowledge the responses are true. No waiver or modification of the Application will be accepted unless in writing and signed by an authorized officer of Applicant.

This plan will 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 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 must provide Delta Dental or its designated administrator with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental service 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 service contract or as permitted or required by law. Delta Dental and Applicant must comply with all applicable federal and state laws and 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 service contract to be executed between the Applicant and Delta Dental.

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:			
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? ☐ Yes ☐ No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
Broker/Agent Signature:		Date:	

GENERAL AGENT INFORMATION

General Agent Name: LISI, Inc.		State License: 0672595	
National Producer Number:			
Contact Email: mmehta@lisibroker.com	Phone: 650-348-4131	Fax: 1-844-547-4329	
Company Name: LISI, Inc.	SSN/TIN: 97-2757978	Is Company Inc.? ☑ Yes ☐ No	
Commission Mailing Address: 1600 W. Hillsdale Blvd., Ste. 203	City: San Mateo	State: CA	Zip Code: 94402
Commission(s): 4%	Payable to: LISI, Inc.		
General 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 #: ____________________
DeltaCare USA Group #: ____________________
Delta Dental Secondary PPO Group #: ____________________

TPA Employer #: ____________________
TPA Employer #: ____________________
TPA Employer #: ____________________

CoPower *SELECT* Program

Group Information - (skip this section if enrolling in Delta Dental SBP Plan) - CoPower communication is by electronic mail.

Company Name:		DBA:
Street Address:		
City:	State:	Zip:
Billing Address *(if different)*:		
City:	State:	Zip:
Contact Name:		Title:
E-mail:	Phone:	Fax:
If you wish to opt out of E-mail 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)*:

Delta Dental

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

Choice Plans (Non-Voluntary); 5-99			**Choice DeltaCare USA; 5-99**
Options	**Ortho Option**	**Employer Contribution**	☐ Plan 10B, Non-Voluntary
☐ Premier Plans ☐ PPO Plans	☐ 1000 Max ☐ 1500 Max ☐ 2000 Max	(10+ enrolling) ☐ Yes ☐ No	Employee: 100% (required) Dependent: _____ (minimum 50%)	**Employer Contribution** Employee: 100% (required) Dependent: _____ (minimum 50%)

Vision Service Plan (2-1000)

Total # of Enrolling Employees: _____	Employer Contribution	Employee: _____ *(100% for all plans except the voluntary plans)* Dependent: _____ *(minimum 0%)*
Prior Carrier: ☐ None	☐ Choice Plan A $20 ☐ Choice Plan B $25 ☐ Choice Plan B $25 ($130) ☐ Choice Plan B $20/$20 Vol	☐ Choice Plan B $10/$25 Vol ☐ Choice Plan C $25* ☐ Vol ☐ Choice Plan C $25 ($130) ☐ Choice Plan C $20/$20 Vol	☐ Choice Plan C $10/$25 Vol ☐ Signature Plan B $25 ☐ Easy Options* ☐ Vol *Employer Sponsored Plan
Cancel Date:		

Landmark Chiropractic & Acupuncture (2-199) *Enrollee must be enrolled in group medical to qualify*

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

Unum Life/AD&D (2-249) and LTD (10-249)

Basic Life and AD&D		**Voluntary Life & AD&D**	**Unum LTD**
Prior Carrier: ☐ None		Prior Carrier: ☐ None	Prior Carrier: ☐ None
Cancel Date:		Cancel Date:	Cancel Date:
Total # of Enrolling Employees: _____		Total # of Enrolling Employees: _____	Total # of Enrolling Employees: _____
Available to all groups ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000	Only for groups with 10+ Enrolled Employees ☐ $50,000 ☐ $100,000 ☐ $150,000	Voluntary Life: ☐ Supplemental (2+ enrolling) ☐ Standalone (10+ enrolling) Each member or spouse applying must submit the Unum Voluntary Life Application. A completed Evidence of Insurability Form is only required for amounts over Guaranteed Issue.	Select Elimination Period: ☐ 90 day ☐ 180 day ☐ 360 day Healthcare Protect Rider: ☐ Yes ☐ No If Yes, choose benefit: ☐ $300 ☐ $500 ☐ $1,000
Please sign the Basic Term Life Applications on **page 6**. If enrolling in Voluntary Life & AD&D, check the Group Lifestyle Protection Accidental Death & Dismemberment Benefits box.			Please complete and sign the Application for Group Insurance - LTD on **page 7**

Unum Life/AD&D (2-249) and LTD (10-249)

Class Schedule: (*Available to groups of 10 or more employees. 5 class maximum with a minimum of 3 employees per class. Further class specifications may be provided on a separate sheet. Refer to Program Guidelines for details on class benefits.*)

☐ **Schedule A:** Same coverage for all Job Classifications ☐ **Schedule B:** Coverage Differs by Job Classification Class 1: _____ Class 2: _____ Class 3: _____

Administrative Fee Policy – Charged monthly

$10 – Unum Life, & Unum LTD $15 – VSP *(2-4 Groups receive a 1 year discounted rate of $10)*	$15 – Any combination of VSP, Unum Life, & Unum LTD No fees applicable – Delta Dental and Landmark Chiro/Acu

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: _____

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

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

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: ☐ Cal-COBRA ☐ Fed-COBRA

Cal-COBRA: *Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year**

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.*

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, enter the premium amount and attach a copy of a voided check.

☐ 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. Producers (agent or agency) must have a signed Producer Agreement with CoPower.)

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: ☐ Producer ☐ Agency			Make commissions payable to: ☐ Producer ☐ Agency		
Multiple producer split: ☐ Yes ☐ No		Percentage of split: %	Multiple producer split: ☐ Yes ☐ No		Percentage of split: %

Basic Term Life

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