

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 the Group Eligibility Information/Carve-out/COBRA, Payment/Invoice, and Producer Statement sections on page 3 **AND** Delta Dental SBP Group Dental application on pages 4 through 8.

For Delta Dental Choice, VSP, Unum, and Landmark - Complete only the CoPower *SELECT* portion of the application on pages 2 through 3.

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

For Multiple Producer Splits - Complete the Broker/Agent Information section on page 7 **AND** the Producer Statement on the CoPower *SELECT* section on page 3.

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 groups not submitting the full census:
 - Completed waivers and declination of coverage documents for employees waiving due to other dental coverage. Waivers not required for Voluntary plans.
 - 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 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 9).
- ☐ For Unum LTD:
 - Complete “Application for Group Insurance – LTD” if enrolling in LTD (page 10).
- ☐ 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.

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 <input type="checkbox"/>		SIC Code (required):
Type of Business:	Tax ID #:	Date Business Established:
Employer is a: <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Public Agency <input type="checkbox"/> Other (Please Explain): _____		Requested Effective Date: _____ HR360 Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> Premier Plans <input type="checkbox"/> PPO Plans	Options <input type="checkbox"/> 1000 Max <input type="checkbox"/> 1500 Max <input type="checkbox"/> 2000 Max	<input type="checkbox"/> Plan 10B, Non-Voluntary Employer Contribution Employee: <u>100%</u> (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: <input type="checkbox"/> None	<input type="checkbox"/> Choice Plan A \$20 <input type="checkbox"/> Choice Plan B \$25 <input type="checkbox"/> Choice Plan B \$25 (\$130) <input type="checkbox"/> Choice Plan B \$20/\$20 Vol	<input type="checkbox"/> Choice Plan B \$10/\$25 Vol <input type="checkbox"/> Choice Plan C \$25* <input type="checkbox"/> Vol <input type="checkbox"/> Choice Plan C \$25 (\$130) <input type="checkbox"/> Choice Plan C \$20/\$20 Vol	<input type="checkbox"/> Choice Plan C \$10/\$25 Vol <input type="checkbox"/> Signature Plan B \$25 <input type="checkbox"/> Easy Options* <input type="checkbox"/> 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: <input type="checkbox"/> HMO <input type="checkbox"/> PPO	Plan Type: <input type="checkbox"/> Chiro Only <input type="checkbox"/> Chiro + Acu	Type <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)

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

Basic Life and AD&D		Voluntary Life & AD&D	Unum LTD
Prior Carrier: <input type="checkbox"/> None		Prior Carrier: <input type="checkbox"/> None	Prior Carrier: <input type="checkbox"/> None
Cancel Date:		Cancel Date:	Cancel Date:
Total # of Enrolling Employees: _____		Total # of Enrolling Employees: _____	Total # of Enrolling Employees: _____
Available to all groups <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000	Only for groups with 10+ Enrolled Employees <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000	Voluntary Life: <input type="checkbox"/> Supplemental (2+ enrolling) <input type="checkbox"/> 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: <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day <input type="checkbox"/> 360 day Healthcare Protect Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, choose benefit: <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$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 – Any combination of VSP, Unum Life, & Unum LTD
\$15 – VSP (2-4 Groups receive a 1 year discounted rate of \$10)	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 ☐ NoIs 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: <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: %



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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Applicant <input type="checkbox"/> Other (provide name and email, address or fax number):					
I, the Contract holder, authorize the broker to manage eligibility on my behalf: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> #	PPO: <input type="checkbox"/> #	PPO: <input type="checkbox"/> # PPO Plus Premier™: <input type="checkbox"/> # <input type="checkbox"/> # <input type="checkbox"/> #	PPO: <input type="checkbox"/>) PPO Plus Premier: <input type="checkbox"/>) <input type="checkbox"/>)
# h	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Orthodontic Services (Optional)			<input type="checkbox"/> No <input type="checkbox"/> Child Only	<input type="checkbox"/> No <input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Child
Orthodontic Lifetime Maximum (Per Enrollee)			<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<input type="checkbox"/> \$1,500
D&P Maximum Waiver®			<input type="checkbox"/> Yes <input type="checkbox"/> No	

DELTACARE® USA BENEFIT DESIGNS – Underwritten by Delta Dental of California

	CORE	ADVANTAGE	DELUXE
Select a DeltaCare USA plan	<input type="checkbox"/> 17B	<input type="checkbox"/> 15B	<input type="checkbox"/> 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

<input type="checkbox"/> Dual Choice 2	D&P Maximum Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Services (Optional) <input type="checkbox"/> No <input type="checkbox"/> Child Only	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
<input type="checkbox"/> Dual Choice 3	D&P Maximum Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Services (Optional) <input type="checkbox"/> No <input type="checkbox"/> Child Only	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$1,000 Low/\$1,500 High <input type="checkbox"/> \$1,500 Low/\$2,500 High
<input type="checkbox"/> Core/Buy-Up	Fee Basis (select one) <input type="checkbox"/> PPO <input type="checkbox"/> PPO Plus Premier	Orthodontic Services (Optional) <input type="checkbox"/> No <input type="checkbox"/> Child Only	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$1,000 Core/\$1,500 Buy-Up <input type="checkbox"/> \$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: _____ (Print Name and Title)	Signature: _____ 
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.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
Broker/Agent Signature:			Date:

GENERAL AGENT INFORMATION			
General Agent Name:		State License:	
National Producer Number:			
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
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 #: _____	TPA Employer #: _____
DeltaCare USA Group #: _____	TPA Employer #: _____
Delta Dental Secondary PPO Group #: _____	TPA Employer #: _____



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 Accidental Death & Dismemberment Benefits ☐ Group Short Term Disability Benefits
☐ Group Lifestyle Protection Life Benefits ☐ Group Lifestyle Protection Accidental Death ☐ Group Long Term Disability Benefits
☐ Group Universal Life Benefits & Dismemberment 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 _____ (mm/dd/yyyy) By: _____ (Signature and Title)

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

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
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.

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

AE-1080-CA