# CoPower ONE Employer Application • New York

| **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: ☐ | | Tax ID #: |
| SIC Code *(required):* Type of Business: | | Date Business Est: |
| 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

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 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. Carveouts will be classified as level 2 regardless of true industry SIC)*

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.*

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

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

## 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 is available for 2+ enrolling employees.

Good ☐ Better ☐ Better Plus ☐ Best ☐ Plan Type *(choose one:)* PPO ☐ HMO ☐ Dual Choice ☐

MPB PPO (5-99)* ☐ MPB HMO (2-99)* ☐ Dual Choice MPB PPO/HMO ** ☐
MPB PPO Ortho Option (5-99)* ☐
**Minimum Participation Base (MPB) plans include dental & vision only*
***A minimum of 5 enrolled in PPO plan and a minimum of 2 enrolled in HMO 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 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 Benefit Add-ons: Unum Enhanced Life and Voluntary Life

**Unum Enhanced Life Option:**
$35K ☐ $50K ☐ $100K ☐ $150K ☐
*Select one to replace the standard life amount and sign the Unum application page. 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 Unum Application page. Each employee or spouse applying must submit the Unum Voluntary Life app.*

## 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) _____

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 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: | | |
| ST: | Zip: | Date: | ST: | Zip: | Date: |
| Phone: | Fax: | | Phone: | Fax: | |
| Email: | | | Email: | | |
| 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: ____% | | |

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:**<br>☐ $1,000 Delta Dental PPO<br>**Minimum Participation Based:**<br>☐ MPB $1,500 Delta Dental PPO<br>☐ MPB $1,500 Delta Dental PPO + Ortho | **PPO (Better):**<br>☐ $1,500 Delta Dental PPO + Ortho<br>**PPO Plus Premier (Better Plus):**<br>☐ $1,500 Delta Dental PPO Plus Premier + Ortho | **PPO Plus Premier:**<br>☐ $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 #: _____

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 _____ _____ _____
(City) (ST) (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)