

**APPLICATION FOR GROUP LIFE, ACCIDENTAL DEATH &
DISMEMBERMENT, SHORT TERM DISABILITY, LONG TERM
DISABILITY, INSURANCE POLICY**

A. GENERAL INFORMATION

1. FULL LEGAL NAME OF EMPLOYER: _____

2. STREET ADDRESS: (City, County, State, Zip Code) _____

3. FORM OF ORGANIZATION: ☐ Corporation ☐ Association ☐ Proprietorship ☐ Partnership

4. LIST ALL SUBSIDIARIES to be included: _____

5. EFFECTIVE DATE: _____

6. TAX ID NUMBER: _____ NATURE OF BUSINESS: _____

7. EMPLOYER PHONE NUMBER: _____ EMPLOYER FAX NUMBER: _____

EMPLOYER E-MAIL ADDRESS _____

The Effective Date of the insurance is subject to approval of this application by Unimerica Life Insurance Company

B. TYPE OF INSURANCE ELECTED

	Yes	No	No. of Eligible Employees	Percent of Employee Contribution
Basic Life Insurance				
Basic AD&D				
Supplemental Life Insurance				
Supplemental AD&D Insurance				
Dependent Basic Life Insurance				
Dependent Basic AD&D Insurance				
Dependent Supplemental Life Insurance				
Dependent Supplemental AD&D Insurance				
Short Term Disability				
Long Term Disability				

C. ADDITIONAL INFORMATION

1. Deposit submitted with application: _____ If the policy is issued, the deposit will apply towards the first month's premium

2. Will all or part of this policy replace similar coverage? ☐ Yes ☐ No

If Yes, show Carrier(s), Policy Numbers, and Termination Dates: _____

D. AGREEMENT

The Employer and Unimerica Life Insurance Company ("we", "us" or "our") agree that:

THE APPLICATION shall form the basis for and become part of any policy issued.

PREMIUM RATES shall: (1) be subject to all provisions in that policy; and (2) be binding on both Employer and us.

LIABILITY OF THE COMPANY: We will have no liability until this request has been approved at Our Administrative Office.

AUTHORITY OF AGENTS: No agent can change the terms of this request or any policy We issue. No agent can waive any of our rights or requirements or extend the time for any premium payments.

CHANGES AND CORRECTIONS: The acceptance of any policy issued on this request shall constitute ratification of any correction or amendment made by Us. Changes are an amendment to and form a part of the original request and any policy issued.

General Agent: Warner Pacific Insurance Services

Agent/Broker Information			
Agency		Tax ID Number	
Broker Name		Signature	Social Security #
Phone Number	Email Address		Date
Broker # 2 Name (if applicable)		Signature	Social Security #
Phone Number	Email Address		Date
Commissions payable to:		Broker Commission Schedule _____	

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Dated at _____ this _____ day of _____, _____.

Employer: (full legal name) _____

Signature of Authorized Person: _____

Print Name and Title _____

Licensed Resident Agent (signature) _____

P.O. Box Address (including zip code) _____

Printed Name of Agent and License Number _____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Alabama:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For applicants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in New Mexico:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

For applicants in Oklahoma:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in Oregon:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Pennsylvania:

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 subjects such person to criminal and civil penalties.

For applicants in Tennessee, Virginia and Washington:

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

For applicants in all other states:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ELECTRONIC FORMS NOTICE

Unimerica Life Insurance Company ("Unimerica") will provide the Employer with an electronic transmission of the Entire Group Contract (Group Policy, Certificate of Coverage ("Certificates"), any attached Application, and any Group or Certificate rider, endorsement or amendment). The provisions of the Group Policy, issued by Unimerica to the Employer states that Unimerica will furnish Certificates to the Employer for delivery to each covered employee ("Employee"). By providing the Employer an electronic transmission of the Certificates, Unimerica is satisfying its obligation under the Group Policy.

The Entire Group Contract produced by Unimerica and furnished to the Employer are the legal insurance documents that describe the terms and conditions of the benefits provided under the Group Policy and contain text required by state and federal law. Upon receipt of the electronic Entire Group Contract the Employer must agree to the following:

1. The Employer will distribute the Certificates to each Employee in a timely manner.
2. The Employer will utilize the text contained in the electronic transmission solely for the purpose of distributing the Certificates and appropriate amendments on-line or printing the Certificates for the Employees insured under the Group Policy. The Employer will include a notice of disclaimer to the Employee as provided in Item 5 below.
3. The Employer will not make any alterations, additions or deletions to the text of the Certificates without Unimerica's prior written consent. The Employer will distribute any replacement certificates or updates to the Certificates, in a timely manner, as directed by Unimerica upon advance notice.
4. The Employer will not use Unimerica's name, service marks, trademarks or other legally protected property rights without Unimerica's written consent.
5. If there is a discrepancy between the provisions of the Employer's on-line or printed Certificates and the provisions of the Certificates furnished by Unimerica, the provisions of Unimerica's Certificates will prevail.
6. To the extent permitted by law, the Employer will agree to indemnify and hold Unimerica harmless from any suit, loss or damage incurred by Unimerica as a result of the Employer's use of the electronic transmission.
7. The Employer must agree that Unimerica can revoke its consent to use said electronic transmission for distributing Certificates at any time upon advance notice. In the event of such revocation, the Employer agrees to immediately stop distributing Certificates that are derived from the electronic transmission.
8. Upon request, Unimerica shall have the right to review the Certificates that are distributed on-line or printed by the Employer.
9. In the event the Employer distributes the Certificates to Employees using electronic means, the Employer will make available printed Certificates to those Employees who either: (a) lack on-line access and the ability to convert electronic documents into paper form at their worksite or (b) request a printed copy.

The Employer has the option to request that Unimerica provide the printed Entire Group Contract and/or a supply of printed Certificates for the Employer to distribute to each Employee. A request for the printed Entire Group Contract and/or a supply of printed Certificates can be made on the New Case Information Checklist Unimerica will send to the Employer for completion, prior to producing the Entire Group Contract.