

**APPLICATION FOR GROUP PARTICIPATION IN THE SCS  
 GROUP LIFE INSURANCE TRUST TRUSTED IN THE STATE OF  
 RHODE ISLAND FOR LIFE, ACCIDENTAL DEATH AND  
 DISMEMBERMENT, SHORT TERM DISABILITY, LONG TERM  
 DISABILITY INSURANCE POLICY**

**A. GENERAL INFORMATION**

1. FULL LEGAL NAME OF ENROLLING GROUP: \_\_\_\_\_
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: \_\_\_\_\_  
 The Effective Date of the insurance is subject to approval of this application by United HealthCare Insurance Company

**B. TYPE OF INSURANCE ELECTED**

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

\* Dependent Life must always be combined with Employee Life

**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 Date: \_\_\_\_\_

**D. AGREEMENT**

The Employer and United HealthCare Insurance Company ("we", "us" or "our") agree that:  
**THE REQUEST TO PARTICIPATE** 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.

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 Arkansas and Louisiana:**

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.

**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 District of Columbia:**

**WARNING:** It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

**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, New Mexico, Ohio, and 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 Maine, Tennessee and Virginia:**

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.

**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 Oregon:**

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**For applicants in all other states:**

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.

## AGENT/BROKER DISCLOSURE

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.

By signing below, the Employer acknowledges receipt of this Agent/Broker Disclosure.

Employer: (full legal name)

\_\_\_\_\_

Signature of Authorized Person:

\_\_\_\_\_

## ELECTRONIC CERTIFICATE OF COVERAGE NOTICE

United HealthCare Insurance Company (“UHIC”) will provide the Employer with an electronic transmission of the Certificate of Coverage (“Certificates”). The provisions of the Group Policy, issued by UHIC to the Employer states that UHIC will furnish Certificates to the Employer for delivery to each covered employee (“Employee”). By providing the Employer an electronic transmission of the Certificates, UHIC is satisfying its obligation under the Group Policy.

The Certificates produced by UHIC 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 Certificate(s) 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 Section 5 below.
3. The Employer will not make any alterations, additions or deletions to the text of the Certificates without UHIC’s prior written consent. The Employer will distribute any replacement certificates or updates to the Certificates, in a timely manner, as directed by UHIC upon advance notice.
4. The Employer will not use UHIC’s name, service marks, trademarks or other legally protected property rights without UHIC’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 UHIC, the provisions of UHIC’s Certificates will prevail.
6. To the extent permitted by law, the Employer will agree to indemnify and hold UHIC harmless from any suit, loss or damage incurred by UHIC as a result of the Employer’s use of the electronic transmission.
7. The Employer must agree that UHIC 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, UHIC 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 the UHIC provide a limited or full supply of printed Certificates for the Employer to distribute to each Employee. A request for a supply of printed Certificates can be made by completing the below form. This form can be given to your sales representative or mailed to: Unimerica Workplace Benefits, Contract Services MN010-W115, 6300 Olson Memorial Highway, Golden Valley, MN 55427.

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### REQUEST FOR PRINTED SUPPLY OF CERTIFICATES

\_\_\_\_\_ (*insert Employer’s full name*) is exercising their option to request that UHIC print a limited or full supply of Certificates for the Employer to distribute to their employees.

- Indicate number of desired printed Certificates when limited supply is being requested \_\_\_\_\_
- List number of employees when full supply of printed Certificates is being requested \_\_\_\_\_

**Certificates should be shipped to:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Supplemental Case Information

ADDITIONAL INFORMATION REQUIRED FOR INSTALLATION
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<b>1. Employer Tax ID Number</b>	
<b>2. Group Contact's Name</b>	
<b>3. Group Contact's Phone #</b>	
<b>4. Group Contact's email address</b>	
<b>5. Nature of Business or SIC code</b>	
<b>6. Waiting period for new hires</b>	First of the month after <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days