California Consumer Privacy Act (CCPA)
Notice at Collection

Unico American Corporation and its subsidiaries ("Unico") provide this notice at collection pursuant to the California Consumer Privacy Act of 2018 (Cal. Civ. Code § 1798.100, *et seq*.). The purpose of this notice is to provide you with a list of the categories of personal information that may be collected by Unico, and how that information may be used.

For the purposes of this notice, "personal information" refers to information that identifies, relates to, describes, is reasonably capable of being associated with, or could reasonably be linked, directly or indirectly, with you or your household.

Categories of Personal Information Collected	Business and/or Commercial Purpose for Use
• **Identifiers**, such as your first and last name, producer number, email address, mailing address, social security number, driver license number, vehicle information, and other personal identifiers. • **Categories of personal information described in California Civil Code § 1798.80(e) not otherwise listed above**, such as your signature, physical characteristics or description, insurance policy number, education, employment, employment history, bank account number, credit card number, or any other financial information, medical information, or health insurance information. • **Characteristics of protected classifications under California or federal law**, such as your race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status. • **Commercial information**, such as quote history, claims history, insurance coverage, vehicle information, and other purchasing or consuming histories or tendencies. • **Professional or employment-related information**, such as place of employment, previous employment, and other professional and employment information. • **Some forms of geolocation data**, including country, region, city, postal/ZIP code, and time zone.	• To obtain a quote. • To facilitate and/or investigate a claim. • To facilitate a request for products or services. • To complete a producer application or producer agreement. • To communicate with you. • To complete surveys or other statistical gathering operations. • To ensure compliance with relevant laws and regulations, including contractual obligations. • To perform a service for a customer. • To detect security incidents and protect against deceptive, fraudulent, or illegal activity. • To debug and repair errors that impair existing functionality of internal resources, networks, and databases.

***AAQHC**, An Administrator*
26050 Mureau Road, Suite 220
Calabasas, California 91302
(818) 591-8700 • FAX (818) 591-8722
(800) 669-8700 • www.aaqhc.com

FOR OFFICIAL USE ONLY

Acct.#: _____

Group Eff. Date: _____

INDIVIDUAL AND FAMILY MEMBERSHIP APPLICATION AND GUIDELINES

Full Legal Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____ Eff. Month: _____

Email (required) _____

I hereby apply for non-voting associate membership in American Association for Quality Health Care (AAQHC) and participation in the AAQHC benefit programs.

I UNDERSTAND THAT:

1. Premium notices will be emailed to the address entered above.
2. Coverage of the various programs may terminate for failure to pay membership dues required by AAQHC, An Administrator.
3. Misrepresentation or omission in answering any part of the application may result in the cancellation of my membership, and I agree to pay for any and all services arising from the misrepresentation or omission.
4. As a member, I will receive the Membership Benefits package and may be eligible for optional programs available through AAQHC.
5. There is a one-time enrollment fee of $10.00 payable with the application.
6. The monthly membership dues are $6.00 per month, beginning the second month of coverage.
7. All membership dues are non-refundable.
8. The effective date for coverage is the first of the month only. Policies cannot be prorated for cancellations or enrollments.
9. The monthly payment for AAQHC membership and any optional benefits must be received in the office of AAQHC, An Administrator, by the 15th of the month preceding the benefit period. Failure to make the monthly payment may cause all AAQHC benefits to terminate. The member is responsible for payment even if premium statement is not received. A $5.00 reinstatement charge will be assessed for all cancelled policies.
10. Returned payments will be assessed a $25.00 service charge and are subject to late charges.
11. I may subsequently terminate my membership with a thirty (30) days' prior written notice to AAQHC, An Administrator, and have no obligation except that which accrued during the time of my membership. If I terminate my membership entirely or if I terminate the dental benefits portion of my membership only, I acknowledge that I will not be eligible to re-apply to AAQHC, An Administrator, for dental benefits for one year from the date of termination.
12. All applications must be received in the office of AAQHC, An Administrator, by the 15th of the month preceding a benefit period (coverage month) in order to be considered for that benefit period. The effective date is always the first of the month following approval of application by the underwriter.
13. It is my responsibility to keep AAQHC, An Administrator, apprised of any change in status as it affects state or federal laws or regulations.

14. AAQHC, An Administrator, reserves the right to deny any application.

15. AAQHC, An Administrator, has the authority to execute all policies and agreements with providers chosen to provide benefits in accordance with any applicable federal and state law.

16. It is understood that AAQHC, An Administrator, and its related entities uses binding arbitration to settle all disputes with its members, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute between AAQHC, An Administrator, and any of its members, including disputes as to medical malpractice, that is as to whether any medical services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute between AAQHC, An Administrator, and its members, including any dispute for medical malpractice, any dispute relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between AAQHC, An Administrator, and any individual(s) seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be.

MAKE ALL CHECKS AND MONEY ORDERS PAYABLE TO **AAQHC**, **AN ADMINISTRATOR**.

I HAVE READ ALL OF THE CONDITIONS AS STATED IN THIS MEMBERSHIP APPLICATION & GUIDELINES. I DECLARE THAT I AM FULLY AUTHORIZED TO SIGN THIS MEMBERSHIP APPLICATION & GUIDELINES ON BEHALF OF MYSELF AND MY ELIGIBLE DEPENDENTS (IF ANY).

_____
Applicant – Please Print

_____ _____
Signature Date

Individual Enrollment Checklist

I/We are applying for the following plans: (Check all that apply.)

Guardian Plans: ☐ LOW-OPTION DHMO ☐ MID-OPTION DHMO ☐ HIGH-OPTION DHMO

☐ DPPO ☐ TERM LIFE $_____

☐ Vision Plan of America ☐ SmileSaver SM600, no Vision ☐ SmileSaver SM600 w/SM10 Vision

BROKER STATEMENT

Broker Name: _____ Broker #: _____

Address: _____ Phone: (_____) _____ – _____

Fax: (_____) _____ – _____

City & State: _____ Zip: _____

Email: _____

Tax ID Number: _____ – _____ – _____

I HAVE REVIEWED AND EXPLAINED TO MY CLIENT ALL OF THE CONDITIONS STATED IN THIS INDIVIDUAL AND FAMILY MEMBERSHIP APPLICATION AND GUIDELINES.

_____ _____
Signature Date