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.

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GUARDIAN

Employee Enrollment / Change Form

NOTE: PLEASE COMPLETE ALL INFORMATION

Insured by:
Guardian Life Insurance Company of America

☐ NEW ENROLLMENT	☐ OPEN ENROLLMENT	☐ CHANGE	☐ REINSTATE	**EFFECTIVE DATE OF ADD / CHANGE** (MM/DD/CCYY)

TYPE OF CHANGE:

☐ **Add Dependent(s)*** Date: _____
☐ **Cancel Employee** Last Date of Coverage: _____
☐ **Cancel Dependent(s)*** Last Date of Coverage: _____
***List Names Below**

☐ **Address Change**
☐ **Transfer to COBRA**
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.

☐ **Retirement**
☐ **Other** _____

NAME *(Last)*	*(First)*	*(M.I.)*	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** (MM/DD/CCYY)

ADDRESS	*Apt. #*	*City*	*State*	*Zip Code*

TELEPHONE	**E-MAIL ADDRESS**
HOME: ( ) **WORK:** ( )	

EMPLOYER NAME	**EMPLOYER ADDRESS**	**DATE OF HIRE** (MM/DD/CCYY)

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* **Last Name First Name M.I.**	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** (MM/DD/CCYY)	**GENDER**	***If you choose a Guardian Dental HMO Option: Enter your choice of Dental Office Number below***	**EXISTING PATIENT Yes No**	***(Check one)***
Employee			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel

DENTAL PLAN OPTION:

☐ LOW-OPTION DHMO ☐ HIGH-OPTION DHMO ☐ 1500 STANDARD DPPO ☐ 1500 UCR DPPO ☐ 2000 STANDARD DPPO ☐ 2500 UCR DPPO ☐ TERM LIFE $_____

***If you choose Guardian Term Life Insurance above, please complete the beneficiary form.**

I hereby apply for the group benefit(s) that I have chosen above.
I understand that I must meet eligibility requirements for all coverage that I have chosen above.
I understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.
I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
I attest that the information provided above is true and correct to the best of my knowledge.
Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
By my signature below, I acknowledge that AAQHC, An Administrator, endorses the Guardian plan of insurance.

EMPLOYEE'S SIGNATURE	**DATE**	**EMPLOYER'S SIGNATURE**	**DATE**