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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GROUP APPLICATION

Insured by: GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (GLIC)

GUARDIAN®

EMPLOYER GROUP INFORMATION

FULL LEGAL NAME OF COMPANY				
TYPE OF BUSINESS		HOW LONG IN BUSINESS		
COMPANY CONTACT	E-MAIL ADDRESS	TELEPHONE #	FAX #	
STREET ADDRESS		CITY	STATE	ZIP
BILLING ADDRESS (IF DIFFERENT)		CITY	STATE	ZIP
EMPLOYER CONTRIBUTION (MINIMUM OF 50%) EMPLOYEE: _____% DEPENDENT: _____%		TAX ID NUMBER:		

ELIGIBILITY INFORMATION

1. Probationary Period for New Hires / Rehires – First of the month following: ☐ Date of hire ☐ 1 mo. ☐ 2 mos. ☐ 3 mos. ☐ _____ mos. (6 max.)
2. Number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30
3. Number of Eligible Employees (including eligible owners) _____
4. Total Number of Enrollees (excluding COBRA enrollees) _____
5. Number of COBRA Enrollees (applying for health coverage) _____
6. Number of Waivers (Please attach "Declination of Coverage" form) _____
7. Has the employer ever held a GLIC Contract? ☐ YES ☐ NO
8. Do the eligible enrollees represent a carve-out either by class, location, or union affiliation? ☐ YES ☐ NO
9. Do you currently have group dental benefits? ☐ YES ☐ NO Carrier Name: _____ Renewal Date: _____

WE ARE APPLYING FOR THE FOLLOWING PLAN(S):

Dental: HMO — ☐ Low-Option ☐ High-Option
PPO — ☐ 1500 Standard ☐ 1500 UCR ☐ 2000 Standard ☐ 2500 UCR

Term Life: $_____ **REQUESTED EFFECTIVE DATE:** _____

AGREEMENT

Please complete all of the information requested before signing this application. Please initial any changes.

It is understood that only employees and dependents of such shall be eligible.

It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company (-ies). No contract of insurance is to be implied in any way on the basis of the completion and submission of the application.

Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.

Any person, who with intent to defraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

The undersigned applicant certifies that to the best of his/her knowledge and belief, all of the responses given are true, correct and complete. The applicant understands that a false statement or misrepresentation in the application may result in loss of coverage in the policy, the rescission of the policy, or a revision of the rates quoted.

I have reviewed the statements made by me on this application, and they are true and complete to the best of my knowledge and belief. By my signature below, I acknowledge that AAQHC, An Administrator, endorses the Guardian plan of insurance.

OFFICER OF THE COMPANY SIGNATURE	OFFICER TITLE	DATE

STATEMENT OF AGENT OR REPRESENTATIVE

I, or we, have complied with the underwriting rules and regulations of Guardian Life Insurance Company of America (GLIC), and have explained to the new applicant, in detail, the coverages and provisions of the plans. To the best of my knowledge and belief, all statements on the Employer Application are complete and true. **I have advised my client not to terminate any existing coverage until this application is accepted.** It is further understood that no broker has the power on behalf of GLIC to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.

BROKER NAME	BROKER ID #	BROKER LICENSE #	DATE SUBMITTED
AGENCY NAME	**TELEPHONE #**	**FAX #**	**E-MAIL ADDRESS**
ADDRESS	**CITY**	**STATE**	**ZIP**
BROKER / CONSULTANT SIGNATURE			**DATE**