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

Individual and Family Dental Enrollment Form

Insured by:
Guardian Life Insurance Company of America

NOTE: PLEASE COMPLETE ALL INFORMATION

☐ **NEW ENROLLMENT** ☐ **CHANGE**	**EFFECTIVE DATE** (MM/DD/CCYY)

TYPE OF CHANGE:

☐ **Add Dependent(s)*** Date: _____ ☐ **Address Change** ☐ **Other** _____

☐ **Cancel Dependent(s)*** Last Date of Coverage: _____

***List Names Below**

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:** ( )	

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)***
Applicant			☐ 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 ☐ MID-OPTION DHMO ☐ HIGH-OPTION DHMO ☐ DPPO ☐ VOLUNTARY TERM LIFE* $_____

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

I hereby apply for the benefit(s) that I have chosen above.
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.
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.

APPLICANT'S SIGNATURE	**DATE**	**SPOUSE'S SIGNATURE**	**DATE**