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

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APPLICATION FOR GROUP COVERAGE: MESVision

Group Applicant

Full Legal Name of Employer/Group:		SIC:
Group Contact:	Email address:	
Address (Street):		Telephone:
City:	State:	Zip Code:

Legal Entity

☐ Corporation ☐ S-Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Trust ☐ Association ☐ Other:

Nature of Business:

Subsidiaries or Affiliates to be Insured: ☐ No ☐ Yes – Full Legal Name(s):

1.

2.

Coverage Requested

(Benefit Frequency, Frame Allowance, Contact Lens Allowance) 1. Plan:	2. Requested Effective Date:
3. Number of Eligible Employees:	4. Number of Employees Enrolling:
5. Number of Eligible Dependents:	6. Number of Dependents Enrolling:

7. Waiting Period: Initial Employees: ☐ None Future Employees: ☐ One Month ☐ Other:

8. Employer Contribution: % Employee / % Dependents

9. All or part of this insurance will replace similar coverage:

☐ No ☐ Yes, please submit copies of the policy(ies) and/or certificate(s)

Prior Carrier: Coverage: Termination Date:

10. Initial Premium Deposit: Minimum First Month Premium, Plus $ _____ Enrollment Fee

TOTAL REMITTED $_____

Agreement

To the best of our knowledge and belief, all information on this application is true and complete. If the application is not complete, AAQHC, An Administrator, reserves the right to reject it and notify in writing. We understand that no coverage will be effective before the date determined by AAQHC, An Administrator, and only if we have paid our first month's contribution plus AAQHC dues and fees.

Authorization

Dated at: (City) (State)	This: (Month) (Day) (Year)
Witness (Licensed Broker/Agent):	By (Authorized Signature):
Print Broker/Agent Name:	Print Name:
Broker/Agent License Number:	Title: