APPLICATION FOR PARTICIPATION IN THE SELECT GROUP INSURANCE TRUST
Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

To: The Trustees of The Select Group Insurance Trust and Unum Life Insurance Company of America

Name of Employer/Applicant _____

Address: _____

_____
(City) (State) (Zip)

requests approval to participate in the above named Group Insurance Trust and that

- ☐ Group Life Benefits
- ☐ Group Lifestyle Protection Life Benefits
- ☐ Group Universal Life Benefits
- ☐ Group Accidental Death & Dismemberment Benefits
- ☐ Group Lifestyle Protection Accidental Death & Dismemberment Benefits
- ☐ Group Short Term Disability Benefits
- ☐ Group Long Term Disability Benefits
- ☐ Group Long Term Care Benefits

be made available to its eligible employees under the terms of the Policy(ies) issued to the Trustee(s) of the Trust. The effective date of this insurance coverage is to be _____ or such other date as the Insurance Company approves, whichever is later. If this request is approved, no insurance for which evidence of insurability is required will become effective until approved by the Insurance Company at its Home Office.

Is there any group life insurance plan in force or being applied for on some or all employees? ☐ Yes ☐ No

If yes, complete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates (mm/dd/yyyy)	Termination Dates (mm/dd/yyyy)

By this application, the Employer/Applicant agrees and accepts the terms of the Trust Agreement for the Trust named above for so long as it elects to participate in the Trust. This includes all amendments to the Trust Agreement and any Rules and Regulations adopted by the Trustee(s) under the same Agreement.

The Employer/Applicant authorizes the Trustee(s) to act as its agent for the purposes set forth in the Trust Agreement. This includes functions relevant to the administration of Group Insurance; including but not limited to: (1) collection of premiums; (2) holding insurance policy(ies); and (3) delegation of agency to insurers. The Employer/Applicant also: (1) agrees to remit regularly the required premium payments; and (2) elects coverage as shown in the Summary of Benefits.

The Employer/Applicant acknowledges that the group policy(ies) under which insurance is provided contain(s) numerous optional provisions which are available in order to provide each employer with the ability to select provisions which meet its own needs. It is understood and agreed that only those provisions which appear in the Summary of Benefits provided to the Employer/Applicant apply to its insurance coverage.

Only approval of this request in writing by the Trustees shall permit the employer/applicant to participate in the above Trust. Insurance will become effective upon approval of the Insurance Company at its Home Office.

Signed at _____ _____
(City and State) (Applicant)

on _____ By: _____
(mm/dd/yyyy) (Signature and Title)

Producer Name: _____ Producer Signature: _____
(Please Print)

SS# / Tax ID#: _____ State ID #: _____ Policy Effective Date: _____
(mm/dd/yyyy)

PRODUCER INFORMATION: For Commission purposes, please list the producers for this application. Use full names, including complete business names. To ensure proper payment of commissions, include each producer's tax identification number (social security number or corporate tax id) and state identification number where applicable. If more than one producer, please be sure to specify the split %. For corporate producers, please specify the signing representative's name and ID #'s.

PLEASE PRINT ALL INFORMATION CLEARLY

	Producer Name (Please print full name)	SS# / Tax ID#	State ID# (where applicable)	Split % age (Must total 100%)	Unum Producer # (If known)
1.					
2.					
3.					

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.