U.S. Risk
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Group Life/Accident & Health Underwriting Supplemental Application

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This underwriting supplement is to be completed if the applicant provides services for any of the following plans: Multi-Employer Trust, Professional Employer Organization (PEO) or MEWA, Public/Government, Taft-Hartley (Union), Health and Welfare Plan (complete a separate underwriting supplement for each plan):

1. Plan Name: _____
   Year plan was established: _____ Number of Participants: _____
   Type of Plan:
   ☐ Multi-Employer Trust/PEO or MEWA ☐ Public/Government ☐ Taft-Hartley (Union) ☐ Health & Welfare Plan
   ☐ Retirement/Pension Plan
   What services does the application provide? _____
   _____
   How long has the applicant been providing services to the plan? _____
2. If a Multi-Employer Trust, PEO or MEWA:
   a. Who formed the plan? _____
   b. How many employers are in the plan? _____
3. If a Public/Government Plan:
   a. Name & Type of Entity: _____
   b. City/County/State: _____
4. If a Taft-Hartley (Union) Plan:
   a. What union are you working with and with what industry are they associated:
   _____
   b. City/County/State: _____
5. If a Health and Welfare Plan:
   a. Is the plan: ☐ Fully Insured ☐ Partially Insured ☐ Self-Insured
   b. If Fully Insured or Partially Insured, what insurance company provides the insurance?
   _____
   c. If Self-Insured, what insurance company provides the "stop loss" or other excess placement?
   _____
6. If a Retirement/Pension Plan:
   a. Is it a: ☐ Defined Contribution ☐ Defined Benefit
   b. Has a favorable IRS Plan Determination Letter been received? ☐ Yes ☐ No
   c. If no, explain why not: _____
   _____
   d. What investment vehicles are used to fund the plan: _____
   _____
   e. Name of product provider(s) of the investment vehicles: _____
   _____
   f. Who is in the role of fiduciary when selecting the investments for the plan? _____
   _____
   g. Who is in the role of fiduciary when directing the investments for the plan? _____
   _____

I understand information submitted herein becomes a part of the application and is subject to the same conditions as stated in the application. I also understand and agree that I am obligated to report any changes in the information provided in this supplement that occur after the date of the application and before policy inception. **MUST BE SIGNED AND DATED BY OWNER, PARTNER OR SENIOR OFFICER OF THE AGENCY APPLYING FOR COVERAGE.**

Name: _____ (print name) Title: _____ (print title)

Signature: _____ (owner, partner or senior officer) Date: _____ (Month/Day/Year)