

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 & Welfare Plan; or Retirement/Pension 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 and 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 & Welfare Plan:  
 a. The plan is:  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. The plan is:  Defined Contribution     Defined Benefit  
 b. Has a favorable IRS Plan Determination Letter been received?  Yes     No  
**If no, explain:**  
  
 c. What investment vehicles are used to fund the plan:  
  
 d. Name of product provider(s) of the investment vehicles:  
  
 e. Who is in the role of fiduciary when **selecting** the investments for the plan?  
  
 f. 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.**

\_\_\_\_\_  
Authorized signature

\_\_\_\_\_  
Date

Typed or printed name: \_\_\_\_\_

Title: \_\_\_\_\_