

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

U.S. Risk, LLC | 14241 Dallas Parkway, Suite 850, Dallas, Texas 75254

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: _____