

Producer Contact: 1.800.43VOICE, Option 2, 2
 Fax Forms to 1.800.543.8573 or email to newaccountservicecenter@coloniallife.com

Account Information

Account name: _____
 Address: _____
 City: _____ State: _____ Zip _____
 Phone: (____) _____ Fax: (____) _____

If this account is associated with another Colonial Life or one of its affiliates' accounts, please provide the name and BCN of the account or master group number:

Account billing address (if different from above address): PIOPAC- 1132 Bishop St., Ste 2101 Honolulu, HI 96813

Contact person for billing and service: Tennyson Lum President
First Name Middle Initial Last Name Title

E-mail address: tlumjr@piopac.com

Are there locations that will be written in NY? Yes No

Number of benefit-eligible employees: _____ Federal Tax ID: _____

Exact nature of business: _____

Will a third party administer, reconcile and/or remit the premium deductions? Yes No

If yes, is the third party a: Payroll Company Professional Employer Organization Other PIOPAC

Please indicate name, address, phone number and contact person PIOPAC-1132 Bishop St., Ste 2101 Honolulu, HI 96813

Tennyson Lum, (808)792-5212, tlumjr@piopac.com. Gabriella Bright, (808)792-5214, gabe@pioneerpacific.com

*A General Service Provider Data Sharing and Confidentiality Agreement may be needed.

Will any deductions be made pretax? Yes No If yes, include Flex Plan Supplemental Form.

Will any group products be offered? Yes No

Will the employer be contributing any premium toward the Colonial Life benefits? Yes No

If yes, select which product line contributions will apply? Individual Group Options

If applicable to your state and company position, as allowed by law, please signify if domestic partner or civil union relationships are recognized by your company? Yes No

Tax Advantage Wellness Programs

I confirm the Colonial Life voluntary products I am offering are not offered alongside or in conjunction with any tax advantage wellness programs, as I understand the company prohibits offering Colonial Life voluntary products in accounts with these products or programs as they are deemed non-compliant with applicable laws and regulations. Yes No

Important Compensation Disclosure Information

Colonial Life is committed to helping working Americans and their families minimize personal financial risk with a comprehensive offering of voluntary benefits through the workplace. Colonial Life compensates producers to facilitate the sale and delivery of these valuable benefits. This compensation might include commissions as well as various incentives and awards.

We support the full disclosure of compensation programs for our products, and your insurance advisor can provide you with complete information about these programs. You may also learn additional information about our compensation programs by contacting our Plan Administrator Service Center at 1.800.256.7004.

Initials of Authorized Officer _____

Is employer/account paying a fee to an insurance advisor for this placement of Colonial Life insurance? Yes No _____

If yes, list advisor(s) names _____

A completed Compensation Consent and Disclosure Form 62291 is required for each insurance advisor receiving a fee.

If fee is paid in the future, it is the employer's responsibility to notify Colonial Life of the change.

The employer account (and/or its assigns) agrees to forward promptly all insurance premiums payroll deducted from its employees to Colonial Life & Accident Insurance Company (hereafter Colonial Life) for payment of employee insurance coverage and to notify Colonial Life promptly of the names of any employees to cease deductions because of termination from employment or otherwise. If the employer fails to notify Colonial Life that an individual's employment has terminated, that an individual has otherwise ceased deductions or where there is some other misunderstanding between the employer and employee concerning the payroll deductions, Colonial Life agrees to reimburse the employer up to one (1) month's premium in the event of loss by the employer as long as a claim has not been paid. Refund of premiums on flexible benefit plan accounts will be made payable to the employer. The issuance of any coverage paid for by payroll deduction pursuant to this agreement does not relieve the employer of the requirements of Workers' Compensation Laws of their state.

Signed at: _____ this _____ day of _____
City and State

Print Name and Title of Authorized Officer

Signature of Authorized Officer

Submitted by _____ **Producer #** _____ **Producer Telephone Number** _____

Coordinator's name:

Coordinator's email address: