Employer Application

Group Dental Coverage and
Group Vision Care Insurance
Provided by United HealthCare Insurance Company

Requested Effective Dates of Coverage: 1/1/2014
Requested Policy Anniversary Date: / /
(All effective dates must be first of the month.)

GENERAL INFORMATION

Group's Full Legal Name: VERATEX INC.
Include names of subsidiaries or affiliated companies

Street Address: 254 FIFTH AVENUE 3RD FLOOR

City: NEW YORK	State: NY	Zip Code: 10001
Contact Name: WEI CHANG		Phone Number: 212-683-9300
Fax Number: 212-889-5573	E-Mail Address of Contact: wchang@warpknittricot.com	

Billing Address (If Different):

Organization Type: ☒ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Political Subdivision ☐ Other

Multi Location Group? ☐ Yes ☒ No	Number of Locations:	Locations:

Nature of Business: TEXTILES	Industry Code:
Employer Identification Number (Tax Id Number) 13-2804148	Subject to ERISA? ☐ Yes ☒ No If yes, ERISA plan number:

DENTAL PLAN PARTICIPATION AND SELECTION

Did the group have dental coverage for the past consecutive [12] months? ☒ Yes ☐ No
If yes, name of prior dental carrier and dates of coverage: EMPIRE BLUE CROSS BLUE SHIELD 11/30/12-12/01/13

# Hours per week to be eligible: 20	Benefit Waiting Period for New Hires: 30 DAYS	☒ Date of event following 30 months of employment ☐ 1st of policy month following _____ months of employment

Benefit Waiting Period Waived for Initial Enrollees: ☐ Yes ☒ No	Total Number of Employees on Payroll: 4	Total Number of full time/ eligible Employees: 4
Number of COBRA participants in total group:	Number of Retirees in total group: (applicable to groups of over 50 eligible subscribers)	
Will employees retired by the Employer be eligible for coverage? ☐ Yes ☒ No	If yes, specify groups eligibility:	

Dental Plan Selected:

Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	Employee				
Two Tier	Employee				
	Family				
Three Tier	Employee				
	Employee + One				
	Family				
Four Tier	Employee				
	Employee + One				
	Employee + Children				
	Family				
		Amount of Binder Check: *** This check must accompany the Group Application			

VISION PLAN PARTICIPATION AND SELECTION

# Hours per week to be eligible:	Benefit Waiting Period for New Hires:	☐ Date of event following _____ months of employment ☐ 1st of policy month following _____ months of employment ☐ Other:

Benefit Waiting Period Waived for Initial Enrollees: ☐ Yes ☐ No	Total Number of Employees on Payroll:	Total Number of full time/ eligible Employees:

Number of COBRA participants in total group:	Number of Retirees in total group: (applicable to groups of over 50 eligible subscribers)

Will employees retired by the Employer be eligible for coverage? ☐ Yes ☐ No

If yes, specify groups eligibility:

Premiums and Contributions

Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Employee Only				
Employee + One				
Employee + Spouse				
Employee + Children				
Employee + Family				
Composite				
	Total Estimated Monthly Premium $			

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If my coverage is approved, premium is payable monthly in advance.

I represent that, to the best of my knowledge, the information I have provided in this Application, including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws, is accurate and truthful. I understand that the Company will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the Group's employees.

United HealthCare Insurance Company disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. {For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to [http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs."]} For specific information about the compensation payable with respect to your particular policy, please contact your producer.

FRAUD WARNING NOTICE{S}: {(Please review the notice that applies in your state.)}

{For applicants in {Arkansas} {and} {West Virginia}:
Any person who knowingly presents a false or fraudulent claim for payment of a los or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.}

{For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.}

{For applicants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.}

{For applicants in Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.}

{For applicants in Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.}

{For applicants in New Mexico:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.}

{For applicants in Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.}

{For applicants in Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.}

{For applicants in Oregon:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.}

{For applicants in the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.}

{For applicants in all other states:
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.}

{For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.}

GROUP SIGNATURE (form must be signed)

Group Authorized Person's Name: WEI CHANG	Title: CONTROLLER
Group Authorized Person's Signature:	Date: 12/26/13

AGENT/BROKER INFORMATION

Agent/Broker Name:		Agency:
Agent/Broker Signature:		Date:
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:
Commissions Payable To:		Agent/Broker Number:

Group dental and group vision insurance products are underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut.