Employee Application For Conversion Coverage
Long Term Disability Insurance

ASSURANT Employee Benefits®

1. Prospective person insured _____ Date of birth _____

2. Address _____
NUMBER AND STREET

_____
CITY STATE ZIP CODE

3. Group policyholder _____

4. Group policy no. _____ 5. Certificate no. _____ 6. Social Security no. _____

7. Effective date of group insurance _____ 8. Termination date of group insurance _____

9. Reason for termination _____

10. Is there now in effect, or applied for but not yet issued, any other coverage (group or otherwise) providing Long Term Disability Benefits? ☐ Yes ☐ No If "Yes," please furnish details of this coverage or a copy of the benefit booklet.

_____

_____

11. Initial quarterly premium _____ **Note**: All checks must be drawn to the order of Union Security Insurance Company. If accepted, are accepted subject to collection.

I HEREBY: A) Request application under a Group Long Term Disability Insurance Conversion Policy to become effective on the day following the date of termination shown in item 8 above, B) declare that the coverage for which application is requested is to replace the Long Term Disability Insurance under the group policy identified in item 4 above, C) agree that the coverage for which application is requested shall not become effective unless application is approved by Union Security Insurance Company according to its underwriting rules and procedures for conversion coverage currently in effect, and D) represent that all of the above statements are, to the best of my knowledge and belief, true and complete.

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 may be guilty of insurance fraud as determined by a court of law.

Signed at _____ Date _____
CITY AND STATE OR OTHER JURISDICTION

Signature _____ Signature _____
WITNESS PROSPECTIVE INSURED

(over)

POLICYHOLDER VERIFICATION *(To be completed and signed by the Group Policyholder)*

1. Name of group policyholder _____ Group policy no. _____

2. Name of employee _____ Cert. no. _____

3. Effective date of applicant's insurance under the group policy _____

4. A. Date applicant's insurance terminated _____

   B. Reason for termination _____

   C. Had the applicant been insured under the Group Long Term Disability Policy for at least 12 consecutive months on the date of termination? (If not solely with Union Security Insurance Company, then under a prior Group Long Term Disability plan, if any, which the Union Security Insurance Company plan replaced?) ☐ Yes ☐ No

   D. Applicant's insured monthly salary on the date of termination $_____

5. Date notice of conversion privilege given to employee _____

6. Is the employee filing a claim for, or currently receiving Group Long Term Disability Benefit? ☐ Yes ☐ No

Signature _____ Date _____
AUTHORIZED POLICYHOLDER REPRESENTATIVE

FOR HOME OFFICE USE ONLY

I.D. no. _____

Cert. no. _____

Date cert. mailed _____

Effective date _____

First premium paid in full _____

Last premium paid _____

Claim paypoint _____

LTD gross benefit _____