Union Security Life Insurance Company of New York
Employee Application For Conversion Coverage
Long Term Disability Insurance

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.

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11. Initial quarterly premium ______________ **Note**: All checks must be drawn to the order of Union Security Life Insurance Company of New York. 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 Life Insurance Company of New York according to its underwriting rules and procedures for conversion coverage currently in effect, and D) certify that all of the above statements are, to the best of my knowledge and belief, true and complete.

Pursuant to Section 403(d) and Regulation 95 of the New York Insurance Law, the following statement applies to our accident and health policies only. "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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Signed at ______________________________ Date ______________
CITY AND STATE OR OTHER JURISDICTION

Signature ______________________ Signature ______________________
WITNESS PROSPECTIVE INSURED

(over)

Administrative Office: PO Box 830607 Birmingham AL 35283
T 866.909.6065

GFSLIC 5 (7/99)
KC1615NY (2/2006)

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 Life Insurance Company of New York, then under a prior Group Long Term Disability plan, if any, which the Union Security Life Insurance Company of New York 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

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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 ______________________