

Extended Employee Application



(Please complete the health questions on page 2 of this application.)

G. O. no. _____

Group policy/participant no.		Account no.	Cert. no.	Employer	Employment location/phone no.
Employee name (last, first, initial)			Part-time employ. date Month Day Year	Full-time employ. date Month Day Year	Employee date of birth Month Day Year
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No	Earnings _____	Employee Soc. Sec. no.	
Job title or position			<input type="checkbox"/> Hourly No. hrs. per week _____	State of residence	
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Employee home address and phone no.	
			<input type="checkbox"/> Other _____		
Status: (If status area is not completed, we consider the employee to be active.)					
<input type="checkbox"/> Retired <input type="checkbox"/> Continuation <input type="checkbox"/> Leave of absence <input type="checkbox"/> Other _____					
Reason _____ Date _____					

Please mark X in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: Basic Life _____ Optional Additional Life _____ Amount in force _____
 Accidental Death & Dismemberment _____
 Short Term Disability Optional Additional STD _____ Amount in force _____
 Long Term Disability Optional Additional LTD _____ Amount in force _____
 Dental

Dependent: **Please mark X** in box before the dependents to be covered: Spouse Children
 Dependent Life _____ Amount in force _____
 Optional Additional Dependent Life _____ Amount in force _____
 Dependent Dental

Note—Coverages not specifically elected will not be made effective, even if not refused.
 ELECTIONS NOT VALID WITHOUT SIGNATURE.

Were you covered under another dental plan within the last 31 days? Yes No
 If "Yes," termination date _____ Reason for termination of other coverage _____

If spouse coverage is being applied for, complete the following.

	Date of Birth				
Name of Spouse	Month Day Year	Social Security No.	Employer	Current Dental Insurance Carrier	

Write in the names and dates of birth of children to be covered (subject to plan provisions).

Write in any coverages that you/your dependents are refusing and the reason for refusal.

BENEFICIARIES

Last name	First	MI	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

*If beneficiary is not related to you, please provide Date of Birth, Social Security number, and full address.
 1) Give FULL names and relationships of each beneficiary. 2) If primary/secondary election is not noted, the beneficiary will be considered primary. 3) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 4) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

Union Security Insurance Company

Mail to: **Assurant Employee Benefits** PO Box 2939 Clinton Iowa 52733-2939

HEALTH QUESTIONS

Please answer the following questions. If you answer "YES" to any questions, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your eligible dependents.

Applicant: Height _____ Weight _____ **Spouse:** Height _____ Weight _____

- | | Yes | No |
|---|--|--|
| 1. Have you or your dependents gained or lost 10 or more pounds during the past 12 months?
If "Yes," how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years:
a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?
b) Used any illegal drugs? | <input type="checkbox"/>
<input type="checkbox"/> | <input type="checkbox"/>
<input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or your dependents pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or your dependents used tobacco, in any form in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your dependents ever had, been medically diagnosed, treated or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years or immune system disorder?
"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure. | <input type="checkbox"/> | <input type="checkbox"/> |

Name, address and telephone no. of personal physician _____

REMARKS-If you answered "YES" to any health question above, please provide details below.

Ques. No.	First Name	Description of illness, injury, or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects/ results	Name and address of attending physician or hospital (<i>Include zip</i>)

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

- 1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company.
- 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy.
- 3) Authorize any required deductions from my earnings.
- 4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death.
- 5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
- 6) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured.
- 7) Have read, understood and received a copy of this application and the NOTICE REGARDING MEDICAL INFORMATION BUREAU, CONSUMER REPORTS AND CONFIDENTIAL ABUSE INFORMATION.
- 8) Understand that I have the right to select any dental care provider of my choice.
- 9) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.

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.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau or any other organization to give Union Security Insurance Company or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to Union Security Insurance Company or its reinsurers to release any information to other life insurance companies as I may come in contact with.

I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for thirty months from the date shown below if for purposes other than a claim for benefits. If a claim for benefits, this authorization will be valid for the term of coverage of the policy if health insurance, or for the duration of the claim if life insurance. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Employee's signature _____ Date _____

Spouse's signature (if spousal coverage) _____ Date _____

**NOTICE REGARDING MEDICAL INFORMATION BUREAU,
CONSUMER REPORTS AND CONFIDENTIAL ABUSE INFORMATION**

In considering applications for insurance or claims for benefits, information from various sources must be considered. These include the results of the proposed or active insured's physical examination, if required, and any reports we may receive on the proposed or active insured's physical or mental health from health professionals and health facilities that have information about the proposed or active insured.

In addition, an investigative consumer report may be obtained, based on interviews with neighbors, acquaintances and business contacts, concerning the character, general reputation, personal characteristics, and mode of living of any individuals involved in an application. Upon written request, the Company (Union Security Insurance Company) will furnish detailed information as to the nature and scope of any such investigation, inform you if it was requested, and if it was, also furnish you with the name and address of the reporting agency to whom the request was made. You may inspect and receive a copy of such investigative consumer report by contacting the reporting agency.

Information regarding factors affecting insurability will be treated as confidential and, if found, domestic abuse status will not be used: solely as a basis for denying, refusing to issue, renew or reissue or cancel or otherwise terminate a policy; to restrict or exclude coverage or benefits of a policy; or to charge a higher premium for a policy.

The State of New Mexico has adopted Title 13, Chapter 7, Part 5 effective January 1, 1999 which applies to insurance companies and insurance support organizations that receive and maintain confidential abuse information. This law protects residents who are or have been victims of domestic abuse as defined by law. Although it is not the Company's practice to reveal location information to anyone other than the applicant/insured, in accordance with this law, the Company has set up a program whereby a victim of domestic abuse may, by written notice, request to be a "protected person" in which their location information will not be disclosed to any person other than those directly involved in an application or claim.

We may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If application is made to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with any information it may have in its file.

Upon receipt of a request, the Bureau will arrange disclosure of any information it may have in the file of the person making such a request. If the accuracy of the information in the Bureau's file is questioned, the Bureau may be requested to make a correction by following the same procedures as those set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone 617.426.3660.

In addition to the brief report described above which we may make to the Medical Information Bureau, we may also release medical information with respect to any physical or mental condition, rehabilitation and other non-medical information in our file to our reinsurer and to other insurance companies to whom application is made for life or health insurance, or to whom a claim for benefits is submitted, but we will not otherwise release information without your further written consent.

If you wish to be considered a protected person, please sign and date below.

Signature of proposed or active insured _____ Date _____

NOTE: This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.