

**Employee Application**



**ASSURANT Employee Benefits**

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<br>Month Day Year   | Full-time employ. date<br>Month Day Year | Employee date of birth<br>Month Day Year |  |
| Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Married<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | Children<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | Earnings<br>_____<br><input type="checkbox"/> Hourly No. hrs. per week _____<br><input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly<br><input type="checkbox"/> Other _____ |  | Employee Soc. Sec. no.                   |  |
| Job title or position   |  |   |  |  | State of residence                       |  |

**Status:** (If status area is not completed, we consider the employee to be active.)

Retired  Continuation  Leave of absence  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:**  Life  Accidental Death & Dismemberment  Optional Additional Life Amt. \_\_\_\_\_  
 Short Term Disability  Long Term Disability Optional Amount:  STD  LTD Amt. \_\_\_\_\_  
 Dental

**Dependent:**  Life  Dental **Please** mark **X** in box before the dependents to be covered:  Spouse  Children

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

|                |                                 |                     |          |                                     |
|----------------|---------------------------------|---------------------|----------|-------------------------------------|
| Name of Spouse | Date of Birth<br>Month Day Year | Social Security No. | Employer | Current Dental<br>Insurance Carrier |
|----------------|---------------------------------|---------------------|----------|-------------------------------------|

Is this replacing existing insurance?  Yes  No The undersigned applicant has read, or had read to him, the completed application and the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

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

Were you covered under another dental plan within the last 31 days?  Yes  No

If "Yes," termination date \_\_\_\_\_ Reason for termination of other coverage \_\_\_\_\_

**Note**— Coverages not specifically elected will not be made effective, even if not refused.

ELECTIONS NOT VALID WITHOUT SIGNATURE.

**Write** in any coverages being refused and reason for refusal.

**BENEFICIARIES** (Please read information below before completing.)

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

**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) Understand that I have the right to select any dental care provider of my choice.
- 8) 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.
- 9) When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

**Any person who, with the 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 have violated state law.**

**This will certify that I HAVE read and understand the above important notice.**

Signature \_\_\_\_\_ Date \_\_\_\_\_