

**Policyholder Eligibility and Participation Statement—  
Contributory or Voluntary Coverage**



**ASSURANT** Employee  
Benefits

I \_\_\_\_\_, a duly authorized officer of  
OFFICER OF THE POLICYHOLDER AUTHORIZED OFFICER TITLE

\_\_\_\_\_, hereby warrant and represent that as  
POLICYHOLDER NAME

of \_\_\_\_\_ has \_\_\_\_\_  
TODAY'S DATE YEAR POLICYHOLDER NAME NUMBER

employees. I further represent that the information I have provided below regarding eligibility and participation in the applicable insurance plans underwritten by Union Security Insurance Company is complete, correct and true to the best of my knowledge and belief.

Coverage	Employer Contribution	Number of Eligible Employees	Number of Participating Employees
Life	Employee _____ %		
	Dependent _____ %		
Short Term Disability	_____ %		
Long Term Disability	_____ %		
Dental	Employee _____ %		
	Dependent _____ %		

**For Dependent coverage only:**

Of the enrolled employees, \_\_\_\_\_ have eligible dependents. We have enclosed \_\_\_\_\_ application cards with \_\_\_\_\_ employees requesting dependent coverage.

**For Voluntary Life insurance:**

Of the eligible employees, \_\_\_\_\_ are males.

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED OFFICER / DATE

\_\_\_\_\_  
WITNESS / DATE

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.