

Employee Dental Application — California



ASSURANT Employee Benefits

G. O. no. _____

| | | | | | | |
|---|---------------------------------------|---------------------------------------|---|--|---|--|
| Group policy/participant no. | Account no. | Cert. no. | Employer | Employment location/phone no. | | |
| Employee name Last First Initial | Full-time employ. date Mo. Day Yr. | Part-time employ. date Mo. Day Yr. | 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 | |
| Employee date of birth Month Day Year | No. hrs. per week _____ | Job title or position | State of residence | Employee Soc. Sec. no. | | |

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: Dental
Dependent: 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 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).

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

If coverage is refused, provide the reason for refusal. _____

IMPORTANT NOTICE TO APPLICANT — PLEASE READ CAREFULLY

My signature on this application certifies that I:

- (1) Apply for the coverage designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverage has been refused, I am not entitled to benefits under that coverage and that if I want to apply later, I understand 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) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured. (6) Understand that I have the right to select any dental care provider of my choice. (7) 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. (8) When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

Signature _____ Date _____