

**Employee Dental Application—Florida**



**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
<b>Write</b> 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 meet the eligibility requirements 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.

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

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

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

**Union Security Insurance Company**  
 Mail to: **Assurant Employee Benefits** PO Box 2939 Clinton Iowa 52733-2939  
 Form 10 (12/98) (FL)