

**Employee Dental Application—New Hampshire**



**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 indicates 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.

**Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.**

**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) (NH)