
Disability Claim Statement—Life Insurance



ASSURANT

Employee
Benefits

- ☞ If you live in the state of Arizona, the following statement applies to you:**
For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- ☞ If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ☞ If you live in the state of California, the following statement applies to you:**
For your protection California law requires the following to appear on this 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.
- ☞ If you live in the state of Colorado, the following statement applies to you:**
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- ☞ If you live in the District of Columbia, the following statement applies to you:**
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ☞ If you live in the state of Florida, the following statement applies to you:**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ☞ If you live in the state of New Jersey, the following statement applies to you:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- ☞ If you live in the state of New York, the following statement applies to you:**
Pursuant to Section 403(d) and Regulation 95 of the New York Insurance Law, the following statement applies to our accident and health policies only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ☞ If you live in the state of Oregon, the following statement applies to you:**
Any person who, with 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 be guilty of insurance fraud.
- ☞ If you live in a state other than mentioned above, the following statement applies to you:**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

Please read the following instructions carefully for proper completion of the attached Life Insurance Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion. If you also have Long Term Disability Insurance with Assurant Employee Benefits, completion of this form may not be necessary. Please contact the Life Benefit Center for information.

Do not separate the pages of this Claim Statement. Additional physician's statements may be obtained from the Life Benefit Center, or by copying the physician's statement included in this statement. Attach any additional physician's statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. After the Employer and Claimant Statements are fully completed, forward the entire statement to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

Instructions for completion of the Employer's sections follow:

Employer Claim Statement—Part 1

Please indicate at the top of the form whether or not this is a new claim.

- 1.–7. Self-explanatory.
8. Effective date of the claimant's Life coverage.
9. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.
10. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.
11. Provide the reason the claimant ceased working.
- 12.–13. Self-explanatory.
14. Any other coverages the claimant has with Assurant Employee Benefits. (i.e., Disability, Medical, Dental, etc.)
15. A–D If the claimant has returned to work, advise us of his/her **current** work schedule. Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.
- 16.–19. The claimant's basic annual earnings as of the determination date indicated in your Life policy. For #16, if the claimant receives any bonuses, commissions, or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.
- 20.–23. Self-explanatory.
24. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

Employer Claim Statement—Part 2

Fully complete this section of the claim statement for **all** claims.

Please attach a copy of the employer's own description of the claimant's position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant's position. This section should be completed by someone who is familiar with the claimant's position; i.e. supervisor.

Physical Aspects

1. Self-explanatory.
2. Please tell us how often the claimant does each of the activities listed, and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.
Never = 0 hours; Occasionally = 1/2–2-1/2 hours; Frequently = 2-1/2–5-1/2 hours;
Continuously = 5-1/2 hours or more
- 3.–5. Self-explanatory.

Stress/Non Physical Aspects

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.



Employer Claim Statement—Part 1

(Please print or type.)

New claim: Yes No

1. Name of employer	2. Group Policy no.	3. Group Participation no.	4. Account no.
5. Full name of claimant	6. Social Security no.	7. Date employed	8. Effective date
9. Date last worked _____ Number of hours worked that day _____	10. Work schedule of claimant at time of disability: _____ days per week _____ hours per day		
11. Reason for not working after this date	12. Was plan effective when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please indicate date of termination _____		
13. Was claimant a member of a union at the time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Does claimant have any other coverage(s) with Assurant Employee Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please advise of the type of coverage(s).			
15. A. Is the insured engaged in any gainful employment, even in a limited way? <input type="checkbox"/> Yes <input type="checkbox"/> No B. If "Yes," please provide the following information: Date insured returned to work _____ Number of hours currently working per week _____ Current salary _____ If the insured returned to work with another employer, please provide us the name and address of this employer. _____ C. Have you and the claimant discussed reasonable accommodations which would allow a return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain. D. If "No," on approximately what date do you expect the insured to be able to return to work, if ever? _____			
16. Basic annual salary (as defined in Policy)	17. How is claimant paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary + Commission <input type="checkbox"/> Salaried <input type="checkbox"/> Commission only <input type="checkbox"/> Salary + Bonus <input type="checkbox"/> Other _____		
18. Date of last increase in the amount of life insurance	19. Amount of life insurance as of date last worked		
20. A. Has the employment of the insured been terminated solely because of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No B. If "Yes," please give date employment was terminated. _____ C. If "No," please explain present employment status. _____			
21. If your group plan is on a self-administered basis, please indicate: A. Date of last premium paid by or on behalf of insured _____ B. Mode of premium payment: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually			
22. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources? <input type="checkbox"/> Salary continuance Amount: _____ per _____ From _____ to _____ <input type="checkbox"/> Workers' Compensation Weekly benefit _____ Effective date _____ <input type="checkbox"/> Retirement or pension Benefit amount _____ Effective date _____ <input type="checkbox"/> Other _____ Lump sum distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. Remarks			
24. Date _____ By _____ Fax no. _____ Phone no. _____ AUTHORIZED SIGNATURE/TITLE			

**Employer Claim Statement—Part 2
Physical/Non Physical Aspects of Job**

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant's job.

Claimant's occupation _____

Signature/Title _____ Date _____

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. of Hours	At Will	May Alternate Positions		
			15-30 Minutes	Hourly	Never
Sitting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STAPLE YOUR OWN JOB DESCRIPTION HERE

2. Claimant must	Never	Occasionally	Frequently	Continuously
A. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Enter data/keystroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Lift: Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Carry Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Push/Pull Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.

Right: Yes No Left: Yes No Both: Yes No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Does job require:

- A. Working at unguarded heights? Yes No
 B. Exposure to marked changes in temperature and humidity or extremes thereof? Yes No
 C. Exposure to dust, fumes, gases, chemicals? Yes No

Stress/Non Physical

- Percentage of time claimant spends answering customer complaints. _____ %
- Percentage of claimant's work primarily judged on production. _____ %
- Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?
 Yes No _____ % of time
- How many employees does this claimant supervise? _____
- Is this claimant routinely subject to close supervision? Yes No
- Percentage of time spent by the claimant working with his/her co-workers. _____ %
- Percentage of claimant's time spent on: _____ % Prescheduled activities
_____ % Random activities
- Percentage of time claimant spends meeting deadlines set by others. _____ %
- Percentage of responsibility the claimant has for the performance of his/her particular department. _____ %

DO NOT DETACH

Claimant Statement—Part 1 (Please print or type.)

Section I

1. Full name		2. Social Security no.		3. Date of birth	
4. Address (street, city, state, zip code)				5. Home phone no.	
6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			8. Your occupation	

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred.		2. Date first unable to work because of this disability.	
3. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date: _____ Part-time _____ Full-time If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time			
4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.			
Name		Address	Dates of consultation First Visit Last Visit
5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.			
Name of Hospital		Address	From To

Section III

1. A. Has your condition prevented you from doing any job for which your education, training or experience qualifies you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. If "Yes," since what date has disability been total and continuous? _____	
C. Are you receiving or have you applied for Social Security Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ineligible If ineligible, explain. _____	
(Please forward a copy of Award or Denial letter from Social Security as soon as it is available.)	
2. A. Do you expect your disability to be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. If "No," about when do you expect to recover or be able to engage in any gainful occupation? _____	
Please indicate the type of coverage provided (Check all that apply.): <input type="checkbox"/> Employer Group <input type="checkbox"/> COBRA <input type="checkbox"/> Conversion <input type="checkbox"/> Individual <input type="checkbox"/> Spouse <input type="checkbox"/> Government <input type="checkbox"/> Other (Specify.) _____	

Section IV

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representatives, any and all such information. **I UNDERSTAND** the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Signature of claimant _____ Date _____

DO NOT DETACH

Claimant Statement—Part 2 (Do not complete this section if you have returned to work, or if disability is for pregnancy.)

Training, Education & Experience

<p>1. What is your level of education?</p> <p>A. Have you received a high school diploma or the equivalent of a high school diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please advise us of the last grade completed. _____ grade</p> <p>B. Have you attended college? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some college <input type="checkbox"/> College graduate <input type="checkbox"/> Post graduate Please specify: Major field of study _____ Degree earned _____ Date last attended _____</p> <p>C. Have you attended any trade schools or received any other special training? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: Type of training _____ Date last attended _____</p>
<p>2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.</p>
<p>3. What was your occupation when disability commenced and what were the usual duties of your occupation?</p>
<p>4. Which of the above job duties are you unable to perform?</p>
<p>5. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Have you asked your employer to provide any accommodations which would allow you to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what accommodations did you request and what was your employer's response?</p>
<p>7. What accommodations do you feel could be made by your employer to allow you to return to work?</p>
<p>8. Have you considered retraining? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what vocational area(s) would interest you?</p>
<p>9. Please list any hobbies, outside interests or activities.</p>
<p>10. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name, address and phone number of the counselor handling your case?</p>
<p>11. Have you contacted your state Division of Vocational Rehabilitation Department? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name, address and phone number of the counselor handling your case?</p>

The patient must pay any costs for completion of this form.

To the Attending Physician

Please read the following instructions before completing this form.

Do not separate the pages of this claim statement. An authorization to release information can be found in Part 1 of the Claimant's Statement.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the reverse side of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient _____		Date of birth _____	Social Security number _____
History	Patient's symptoms result from (<i>Check all that apply.</i>): <input type="checkbox"/> Employment <input type="checkbox"/> Illness		
	<input type="checkbox"/> Auto accident (<i>state in which accident occurred</i>) _____ <input type="checkbox"/> Other accident		
	<input type="checkbox"/> Pregnancy (<i>expected/actual delivery date</i>) _____ Type of delivery _____		
	Date symptoms first appeared _____		Patient's height _____ Weight _____
	First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____		
	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (<i>Specify.</i>) _____		
Name(s) and address(es) of other treating or referring physician(s)			
Hospital name _____ Confinement dates _____ thru _____			
Diagnoses	Diagnoses (<i>including any complications</i>) Subjective symptoms		
	Objective findings (<i>Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.</i>)		
	Attach medical records as appropriate.		
Treatment	Describe treatment program, including dates of any surgery, medications, physical therapy or psychotherapy.		
Psychiatric Impairment	Complete only if applicable.		
	<input type="checkbox"/> Class 1—Patient is able to function under stress and engage in interpersonal relations (<i>no limitations</i>).		
	<input type="checkbox"/> Class 2—Patient is able to function in most stress situations and engage in only limited interpersonal relations (<i>slight limitations</i>).		
	<input type="checkbox"/> Class 3—Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (<i>moderate limitations</i>).		
	<input type="checkbox"/> Class 4—Patient is unable to engage in stress situations or engage in interpersonal relations (<i>marked limitations</i>).		
<input type="checkbox"/> Class 5—Patient has significant loss of psychologic, physiological, personal and social adjustment (<i>severe limitations</i>).			
<input type="checkbox"/> Remarks			
What stress and problems in interpersonal relations has patient had on the job?			
Do you believe a legal guardian or conservator should be appointed for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**HIPAA Authorization for Release
of Protected Health Information—Life**



Insured/Member name _____ SS no. _____
Address _____ City _____ State _____ Zip code _____
Individual who is the Subject of Protected Health Information _____
Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Entities possessing the information identified below, including physicians, any provider of medical services, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of the Individual referenced above.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance company of New York (“Companies”).

I hereby authorize the use or disclosure of protected health information regarding the Individual referenced above, as described below:

Description of information to be disclosed: Records concerning medical advice, care or treatment. This may also include, but is not limited to: information relating to use of drugs or use of alcohol; post-mortem examination reporting, including autopsy, toxicology and investigation reports; accident reports made by ambulance, law enforcement and paramedics; other insurance carriers or a prior life insurance carrier or life insurance policy and related claim information; and financial or employment-related information.

The sole purpose of this disclosure is for the adjudication of a claim for life insurance benefits under the Policy referenced above.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies’ insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it at any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that the Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- The authorization is effective from the date signed below until a final adjudication of the claim for life insurance benefits is reached or 24 months from date of signature, whichever comes first.

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of personal representative _____

Relationship to insured/member _____
(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please make a copy of the signed Authorization for your records. Then please mail or fax the completed and signed Authorization for processing to the appropriate address below, attention Life Claims:

Assurant Employee Benefits, 2323 Grand Boulevard, Kansas City, MO 64108-2670
Fax no. 816.881.8967

Union Security Life Insurance Company of New York, Administered by:
Assurant Employee Benefits, 2323 Grand Boulevard, Kansas City, MO 64108-2670
Fax no. 816.881.8967

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.