FRAUD STATEMENTS

Please read the following before completing the attached form.

If you live in the states of Arkansas or Louisiana, 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 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.

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 an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

If you live in the state of Maryland, the following statement applies to you: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 New Hampshire, the following statement applies to you: 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.

If you live in the state of New Jersey, the following statement applies to you: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 the state of Virginia, 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 have violated state law.

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 Application are completed according to the instructions, and DO NOT SEPARATE the pages.

Group Insurance Preliminary Application

ASSURANT Employee Benefits

Policy no. _____

UNDERWRITING COMPANY: UNION SECURITY INSURANCE COMPANY (THE COMPANY)
(WE, US OR OUR WHEN USED HEREIN REFER TO THE COMPANY.)

APPLICANT INFORMATION *(You and your when used herein refer to Applicant.)*

1. Exact legal name (*as it will appear in the contract and/or certificate)*. Please explain if different from deposit check.

_____

2. Full address and contact numbers of main office. **Note: If PO Box is used, a street address must also be included.**

Address _____

City _____ County _____ State _____ ZIP _____

Telephone no. _____ Fax no. _____ E-mail address _____

Note: The contract will be issued in the state where the main office is located unless otherwise requested and approved.

3. Correspondent's name and title

☐ Mr. ☐ Mrs. ☐ Ms. _____ Title _____

Is Correspondent an employee of the applicant? ☐ Yes ☐ No

If "No," form KC2692 Appointment of Correspondent must be completed, including full address, and submitted with this preliminary application.

Renewal letters to be sent to:

☐ Same as above with copy to broker
☐ Other *(Please provide name, title and full address.)* with copy to broker.

_____
_____
_____
_____
_____

APPLICANT'S BUSINESS INFORMATION

4. Nature of business *(Give details of products, services, manufacturing process and materials used.)* _____

Years in business _____ Employer Tax ID no. _____ SIC code _____ NAICS code *(optional)* _____

5. Business is organized as:

☐ Corporation ☐ Partnership ☐ Proprietorship
☐ Government Funded Non-Profit ☐ Other Non-Profit ☐ Trust
☐ Sub-Chapter S Corp ☐ Professional Corporation ☐ Professional Association
☐ Limited Partnership (LP) ☐ Limited Liability Company (LLC) ☐ Limited Liability Partnership (LLP)
☐ Prof. Limited Liability Co. (PLCC) ☐ Limited Liability Limited Partnership (LLLP) ☐ Political Subdivision
☐ Federal Agency Executive Branch ☐ Yes ☐ No If "Yes," subject to Executive Order 11246? ☐ Yes ☐ No
☐ Church Group If this is checked, it is: ☐ ERISA ☐ Non-ERISA
☐ Other (*Specify.)* _____

6. Financial Status *(If you answer yes to any part, please provide explanation below.)*

☐ Yes ☐ No Has Applicant ever filed or does it anticipate filing for bankruptcy or similar insolvency?
☐ Yes ☐ No Does Applicant anticipate ceasing, materially reducing or altering active business operations?
☐ Yes ☐ No Has Applicant opted out or does it anticipate opting out of Worker's Compensation, Social Security or PERS (if applicable)?

Explanation: _____

AFFILIATE OR SUBSIDIARY INFORMATION

7. Indicate any affiliates or subsidiaries to be covered. An affiliate or subsidiary is a separate firm owned or controlled by the Applicant. Its employees will be insured under the policy **only** if requested below and approved by the Company. Please complete all the requested information for each affiliate or subsidiary to be covered under the policy. See question 5 for business type.

Name _____

Address _____

Nature of Business _____ Business Type _____ SIC Code _____

No. of Employees _____ Percentage owned by Applicant _____

Name _____

Address _____

Nature of Business _____ Business Type _____ SIC Code _____

No. of Employees _____ Percentage owned by Applicant _____

Name _____

Address _____

Nature of Business _____ Business Type _____ SIC Code _____

No. of Employees _____ Percentage owned by Applicant _____

Is separate billing required? ☐ Yes ☐ No If "Yes," give complete details in question 12 of this application.

8. Coverages requested and effective date of coverage(s) *(Please specify if dates differ by coverage.)*

Life and Accidental Death & Dismemberment Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees/ Dependents	No. of Participating Employees/ Dependents
☐ Employer Paid (with matching AD&D)	_____	_____	_____
☐ Employer Paid (without AD&D)	_____	_____	_____
☐ Additional Contributory Life	_____	_____	_____
☐ Dependent Life	_____	_____	_____
☐ Voluntary Life (with matching AD&D)	_____	_____	_____
☐ Voluntary Life (without AD&D)	_____	_____	_____
☐ Voluntary Dependent Life	_____	_____	_____

For Voluntary Life, indicate the number of eligible males _____ eligible females _____

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently making application for any similar group insurance program? ☐ Yes ☐ No If "Yes," please explain.

_____

Short and Long Term Disability Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees	No. of Participating Employees
☐ Employer Paid Short Term Disability	_____	_____	_____
☐ Employer Paid Long Term Disability	_____	_____	_____
☐ Voluntary Short Term Disability	_____	_____	_____
☐ Voluntary Long Term Disability	_____	_____	_____

Are any of your employees eligible for a State Disability Plan? ☐ Yes ☐ No If "Yes," which state(s) _____

Do you provide salary continuance or any kind of income replacement plan (formal or informal) other than the coverages requested above? ☐ Yes ☐ No If "Yes," which of the following best describe the plan? Check all that apply:

☐ Salary Continuance ☐ Short Term Disability ☐ Long Term Disability ☐ Other *(Please describe.)* _____

Do you or can your employees elect to "gross up" (include as taxable income) the cost of disability coverage? ☐ Yes ☐ No

Will the plan(s) requested replace other coverages as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently making application for any similar group insurance program? ☐ Yes ☐ No If "Yes," please explain.

_____

Dental Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees/ Dependents	No. of Participating Employees/ Dependents
☐ Employer Paid Dental	_____	_____	_____
☐ Dependent Dental	_____	_____	_____
☐ Voluntary Dental	_____	_____	_____
☐ Voluntary Dependent Dental	_____	_____	_____

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently making application for any similar group insurance program? ☐ Yes ☐ No If "Yes," please explain.

_____

Other* (must also purchase a fully insured product)

☐ Employee Assistance Program Select type: ☐ Phone and Online ☐ In Person Assessment ☐ Short Term Counseling

If elected, complete form KC3325 Employee Assistance Program Agreement.

☐ Healthy Solutions Discount Card If elected, please complete the Healthy Solutions Group Information form.

* Products provided by third-party vendors under separate agreements with Applicant.

BILLING AND ADMINISTRATION

9. Do you have a Section 125 Plan? ☐ Yes ☐ No **If "No," please proceed to question 10.**
   Will any of the requested coverages be part of the Section 125 Plan? ☐ Yes ☐ No
   If "Yes," please indicate whether contributions are: ☐ Post-tax ☐ Pre-tax ☐ Post or Pre-tax at individual election
   If any part of the contributions are post-tax, please indicate the percentage of premium paid post-tax _____ %.
   Open Enrollment Period for Section 125 Plan _____ Please note, Life Events will be defined per our standard language unless a copy of your 125 Plan is submitted for review and approval.
   Section 125 Plan included? ☐ Yes ☐ No

10. Who will bill the coverages requested?
   ☐ The Company (with online administration included at no cost)
   ☐ Policyholder (Self-Administration) If this option is selected, the Company can prepare the initial bill for all employer paid coverages. Do you want the Company to prepare the initial bill? ☐ Yes ☐ No
   For Self-Administration you must agree to provide a complete census to the Company upon request and at least once a year.
   ☐ Third Party Administrator **Note: TPA must be approved by the Company prior to submitting case and Applicant must complete and submit form KC2691, Appointment of Third Party Administrator.**

11. Premium is to be billed: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
   Additional options for Voluntary coverages: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly

12. Are separate billing accounts required? ☐ Yes ☐ No If "Yes," provide name, address and contact name for each.

   _____

   _____

   _____

   If more space is needed, please provide an attached list and indicate here that an attachment exists. ☐ Attachment

13. For Life Insurance, will you maintain beneficiary information? ☐ Yes ☐ No If "Yes," you must agree to maintain all records pertaining to the beneficiary of life insurance and all subsequent beneficiary changes. Note: All assignments or irrevocable designations must be submitted to the Company for review and approval, accompanied by the original enrollment form.

   If you are not maintaining beneficiaries you must agree to submit the original enrollment form and all subsequent beneficiary changes to the Company.

14. The following applies to **all** coverages unless otherwise stated.
   A. Service Requirement for current employees (hired on or before the effective date) _____ ☐ Days ☐ Months

   _____

   _____

   _____

   B. Service Requirement for future employees (hired after the effective date) _____ ☐ Days ☐ Months

   _____

   _____

   _____

   C. Entry date: ☐ Immediate ☐ 1st of the month occurring on or after ☐ First of the payroll cycle (*Voluntary dental only)*
   ☐ Other *(Specify.)* _____

   _____

   _____

   Note: For Voluntary coverages entry date cannot be immediate.
   D. Full-time definition: ☐ Standard (30 hours for employer paid, 20 hours for Voluntary coverages)
   ☐ Other *(requires Home Office approval).* Please specify request _____
   E. Effective date for changes due to salary changes for **employer paid** coverages ☐ Immediate ☐ Policy Anniversary
   ☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____
   F. Effective date for changes due to salary changes for **Voluntary** coverages ☐ Immediate ☐ Policy Anniversary
   ☐ Other *(Specify.)* _____
   G. Effective date for changes due to age for **employer paid** coverages ☐ Immediate ☐ Policy Anniversary
   ☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____

H. Effective date for changes due to age for **Voluntary** coverages ☐ Policy Anniversary

☐ Other *(Specify.)* _____

I. Termination date for Dental coverage ☐ Immediate *(not available for Voluntary dental)*

☐ End of the payroll cycle *(Voluntary dental only)* ☐ End of the month in which employment terminates.

J. Annual enrollment _____ *(Should coincide with applicant's medical plan or 2 months prior to Policy Anniversary.)*

CERTIFICATE AND CONTRACT INFORMATION

15. Certificates are provided in electronic format for all coverages. Please review the following statement regarding your responsibilities in relation to electronic certificates.

Significance: Electronic Certificates ("e-certs") provide important information about insurance coverage and protection for insureds under the policy. You must agree that you will: (1) Distribute e-certs to insureds under the policy; (2) not release or otherwise transfer e-certs to third parties (other than insureds), without the Company's prior written approval; (3) not alter, modify or otherwise change e-certs and will ensure that adequate security is in place to prevent insureds from doing the same; (4) take measures to ensure that the system furnishing e-certs results in actual receipt of the information by each insured (use return-receipt electronic mail features or periodic review/surveys to confirm receipt) and (5) convey to each insured the **significance** of e-certs, that the certificate is being furnished electronically and that the insured may request and receive a paper copy at no charge.

☐ If you are unable to comply with e-cert responsibilities, check here and paper certificates will be provided to you.

16. Summary Plan Description (SPD): ERISA Plan Information. ERISA requires employers to distribute SPD's for most employer-sponsored benefit plans. To the best of our knowledge, the certificate can serve as your SPD if certain plan information and a statement of ERISA rights are provided with the certificate.

Should we include ERISA information for an SPD? ☐ Yes ☐ No If "Yes," supply the following information.

Name of the plan _____

If other than the policyholder, please provide the full name, address and phone number of the:

Plan sponsor _____

Plan administrator _____

Agent for service of legal process _____

Plan number(s) _____ Note: the plan number is PN501 unless another number is assigned by the employer or the Plan Administrator.

EMPLOYEE INFORMATION AND VERIFICATION

17. Employees at active work

☐ Applicant indicates that all employees are at active work at their usual place of business on date signed on page 6.

☐ There are employees who are not at active work at their usual place of business on date signed on page 6. They are listed below.

Name	Date of Birth	Age	Insurance Amount	Nature of Illness or Reason for Absence

18. Are any employees located outside the United States? ☐ Yes ☐ No If "Yes," please provide the name of the employee(s), location and country of citizenship. Advise how long the employees will be located outside the United States.

_____

_____

_____

Please note, employees working outside the United States are not covered by the policy unless agreed to, in writing, by the Company.

19. If this Preliminary Application is being signed after the requested effective date, you must complete the following:

☐ Applicant indicates that there have been no claims incurred since the requested effective date and Applicant is unaware of any changes in medical condition or status.

APPLICANT AGREEMENT

A. $_____ has been paid by the Applicant to be applied toward the first premium due for coverages requested in this Preliminary Application. This amount will be returned if the requested insurance does not become effective. Cashing of the check by the Company is not acceptance and approval of this Preliminary Application.

B. The Applicant indicates that the information contained herein is true and correct to the best of the Applicant's knowledge and belief and understands that it forms the basis for its request for insurance. Omission or misstatement of known information on this Preliminary Application could affect the validity of any insurance issued and cause denial of a claim.

C. The Applicant understands that the requested insurance will:
   1. Be issued only if the requested insurance is acceptable to the Company and is legally permissible;
   2. Be issued under a group policy(ies) in the language customarily used by the Company;
   3. Be subject to the Company's usual underwriting requirements (including evidence of insurability, if applicable);
   4. Take effect on the date determined by the Company; and
   5. Not be effective until this Preliminary Application is approved and accepted by the Home Office of the Company in Kansas City, MO.

D. The Applicant understands that no agent or broker has the authority to accept or guarantee acceptance of the requested insurance.

E. The Applicant understands that this Preliminary Application may be a request to participate in the Company's Small Group or Voluntary Trust Plans as determined by the Company's underwriting rules. If this item E applies and the Company approves and accepts this Preliminary Application, Applicant agrees to be bound by the terms of the group policy(ies) issued to the Trustees of the applicable Trust Plans.

F. The Applicant agrees to offer the requested insurance to all of its eligible employees.

G. The effective date of the requested insurance for which an employee is required to submit evidence of insurability will be determined in accord with the group policy's terms and will be subject to the active work requirement. The Applicant agrees not to:
   1. Collect or pay premiums (other than the initial deposit) for such insurance before receiving the Company's approval notice; and
   2. Distribute material describing the policy coverage to persons to be insured without the Company's prior written consent.

H. The requested coverage provides benefits for the employee welfare benefit plan established and maintained by the employer - Applicant under the Employee Retirement Income Security Act (ERISA), unless otherwise exempted by law.

I. If the requested insurance is approved and accepted, that insurance will automatically terminate if the premiums are not paid before the end of the grace period following the due date. Payment of premiums for coverage during the grace period is required. Insurance coverage will terminate if the number or percentage of participants falls below that required by the group policy.

J. No one except the President, Senior Vice President or Chief Financial Officer of the Company may make, alter or discharge contracts or waive any of the Company's rights or requirements.

Applicant's Signature _____ Print name _____

Title _____ Date *(required)* _____

Company's representative _____ Date _____

PRODUCER INFORMATION

1. Individual or firm *(legal name)* _____

Writing agent of firm _____
Address _____
City/State/ZIP _____
E-mail address _____
Phone no. _____ Fax no. _____
Payee no. _____ Production Split _____%
License no. _____
Producer _____
Signature _____ Date _____

2. Individual or firm (*legal name)* _____

Writing agent of firm _____
Address _____
City/State/ZIP _____
E-mail address _____
Phone no. _____ Fax no. _____
Payee no. _____ Production Split _____%
License no. _____
Producer _____
Signature _____ Date _____

Note: Agent/Broker must note his/her license number for contract state.