Assurant Employee Benefits Application Form

AGENT NUMBER

Please retain a copy of this application for your records

Your Social Security Number	Last Name	First Name	Middle I.	Sex M ☐ F ☐

Your Date of Birth	Address

Home Phone	City	State	Zip Code+4

IMPORTANT
Write the Dental Facility Number of the dentist(s) you choose from the directory in the space(s) below.

List Dependents to be Enrolled

First Name	Middle I.	Last Name (if different)	Relationship	Date of Birth	Sex	Dental Facility Number
Spouse					M ☐ F ☐	
Child					M ☐ F ☐	
Child					M ☐ F ☐	

Attach a separate sheet of paper for additional children.

Prepayment Fee Amount $________
+Enrollment Fee $35.00
Total Enclosed $________

Select Payment Choice

☐ **Annual Payment -** make the check payable to Union Security Insurance Company.
☐ **Charge my annual prepayment fees**
☐ **Automatic Monthly Bank Draft -** complete the Authorization Agreement on the reverse side of this form.

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
Exp. Date Mo.______ Yr.______

By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of the plan will be provided in the Individual Dental Service Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Union Security Insurance Company my dental records, photocopies or information regarding such procedures to the extent permitted by law. 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 authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company and its affiliated dental companies to use and disclose protected health information.

Agent's Signature________________________ **Date**________ **Subscriber's Signature** ____________________ **Date**__________

10.40 16.74 25.68
109.82 185.86 293.15
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This is an important document that will become part of your contract. Benefits administered by Union Security Insurance Company and provided by DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes.

Authorization Agreement For Automatic Monthly Bank Draft

Name(s)	Social Security Number										Checking ☐ Savings ☐

I (we) hereby authorize Union Security Insurance Company to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.

Bank Name	City	State

Include your Checking or Savings Account Number in the boxes below:

Account Number																

IMPORTANT

If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's prepayment fee and $35 enrollment fee with this form and send them to us.

Prepayment fees are deducted from your authorized account on the 15th of the month prior to the month of benefits. The Authorization Agreement automatically renews if the Individual Dental Service Agreement renews.

John M. Doe
Mary J. Doe
210 East Anystreet
Youngstown NJ 07095

3780

20

3-6-340

Pay to the ORDER OF

VOID

DOLLARS

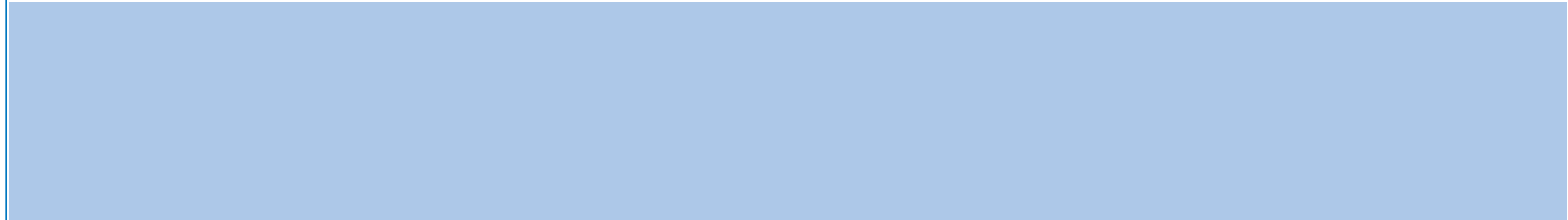
CP CENTRAL NATIONAL BANK
Youngstown, NJ

Memo

A031000095 285 414 3A 3780

This authorization is to remain in full force and effective until Union Security Insurance Company has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature____________________________ **Date**____________



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