

**Voluntary Group Long Term Disability  
Employee Application—Kansas**



Group no. \_\_\_\_\_ Account no. \_\_\_\_\_ Cert no. \_\_\_\_\_

(Please print or type.)

Proposed effective date \_\_\_\_\_

Name of employer \_\_\_\_\_

**Employee Information**—Failure to accurately complete the questions on this application may affect the existence or amount of coverage requested.

Name \_\_\_\_\_ Social Security no. \_\_\_\_\_  
LAST FIRST MI

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Basic earnings \$\_\_\_\_\_  Hourly  Weekly  Monthly  Yearly (Check one.)

Hours worked per week \_\_\_\_\_ Hire date \_\_\_\_\_ Job title \_\_\_\_\_

Work location \_\_\_\_\_  
CITY STATE

**ACCEPTANCE**

Your plan offers disability insurance in \$100 units. You may select an amount from \$500 to \$5,000, in even \$100 units, not to exceed 60% of basic monthly earnings. Refer to the Payroll Deduction Chart to determine your approximate cost per paycheck. Please indicate your benefit level:

- I hereby apply for a monthly benefit in the amount of \$\_\_\_\_\_ subject to the terms of the group policy issued by Union Security Insurance Company.
- Yes**, I would like to participate in the Union Security Insurance Company Voluntary Group Long Term Disability Insurance plan. I understand that by signing and submitting this form to elect coverage, I am authorizing payroll deductions from my salary. I further represent that any information disclosed on this application is accurate and that my answers to any questions are true, accurate and complete, to the best of my knowledge and belief. I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work.

**REFUSAL**

- No**, I do not wish to participate. I understand that I will not be entitled to any benefits under this coverage and will not be able to apply at a later date without providing proof of good health satisfactory to Union Security Insurance Company and that I can be turned down for coverage on the basis of my health. **Coverages not elected will be assumed refused, even if not specifically refused.**

**Notice:** For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met. Payroll deductions may begin prior to the effective date of your insurance.

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 as determined by a court of law.

\_\_\_\_\_  
EMPLOYEE SIGNATURE DATE

**Insurance Company use only (Do not complete.)**

Age \_\_\_\_\_ Premium \_\_\_\_\_ Effective date \_\_\_\_\_ Coverage amount \$\_\_\_\_\_