

**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 Kansas, Maryland or 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 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 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.***

**Union Security Insurance Company**

Mail to: **Assurant Employee Benefits** PO Box 2939 Clinton Iowa 52733-2939

T 800.733.7879

Form 13 (10/99) (MD)

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



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

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**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 certify 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.

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**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 insurability 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.

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

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

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

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