

**Union Security Life Insurance Company of New York
Voluntary Group Long Term Disability
Employee Application**

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 Life Insurance Company of New York.
- Yes**, I would like to participate in the Union Security Life Insurance Company of New York 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.

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 enroll at a later date without providing proof of good health satisfactory to Union Security Life Insurance Company of New York 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 enroll. 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 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 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.

EMPLOYEE SIGNATURE

DATE

Insurance Company use only (Do not complete.)

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

Administrative Office: PO Box 2981 Clinton Iowa 52733-2981
T 888.901.6377