Voluntary Term Life Insurance Employee Application—New Jersey

ASSURANT Employee Benefits

Please print.

Desired effective date of request ____________________

Failure to sign and date the application on page 2 and to accurately complete the questions on this application may affect the existence or amount of coverage. Please refer to your product brochure for available benefit amounts and maximums.

Employer		Policy/part no.	Certificate no.
Insured's name *(last, first, middle initial)*		Sex: ☐ Male ☐ Female	
Date of birth *(month, day, year)*	Social Security number	Job title	
Date of hire *(month, day, year)*	Present salary $ __________ per month/week/year ________ hours per week.		
Beneficiary's name *(last, first, middle initial)*		Relationship	

Have you used tobacco products regularly in the past 12 months? ☐ Yes ☐ No

Employee coverage

☐ Amount elected $ ____________________

☐ Accidental Death and Dismemberment Insurance—equal to your amount of life insurance.
(Coverage not elected will be assumed refused, even if not specifically refused.)

If over the guaranteed issue amount or late entrant, complete all health questions on page 2.

Spouse coverage

Name of the spouse ____________________

Date of birth ____________________

Amount elected $ ____________________
(Amount cannot exceed 50% of the employee's amount.)

Has your spouse used tobacco products regularly in the past 12 months? ☐ Yes ☐ No

If over the guaranteed issue amount, complete all health questions on page 2.

Dependent/Child(ren) coverage
(If applying for dependent coverage, please complete below; amount cannot exceed 50% of the employee's amount. Children under 6 months old are eligible for only $100.)

☐ $1,000 ☐ $5,000

Child(ren)'s name(s)

Last *(if different)*	First	Date of birth

Refusal—Sign below ONLY if you are refusing coverage. If you wish to ENROLL, please sign on page 2.

☐ This is to certify that I have been given an opportunity to participate in the Voluntary Life plan but have declined this coverage. I fully understand that I will not be entitled to any benefits under this coverage. I further understand that if I desire to participate in the Voluntary Life plan at a later date, I must furnish, at my own expense, 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.

Signature ____ Date ____________________

Union Security Insurance Company
Mail to: **Assurant Employee Benefits** PO Box 2939 Clinton Iowa 52733-2939
T 800.733.7879

HEALTH QUESTIONS

Please personally answer the following questions. If you answer "Yes," to any question, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your dependents for whom you are applying for coverage.

		YES	NO
1.	Applicant's height ____________ Weight ____________ Spouse's height ____________ Weight ____________ Have you or your dependents gained or lost 10 or more pounds during the past 12 months? If "Yes," how much ☐ Gained ____________ ☐ Lost ____________	☐	☐
2.	Have you or your dependents within the past 5 years: a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?	☐	☐
	b) Used any illegal drug?	☐	☐
3.	In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for: persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance, recurring diarrhea, fever or infection?	☐	☐
4.	Have you or your dependents ever been diagnosed, treated, or been advised to seek treatment from a member of the medical profession for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immune deficiency syndrome (AIDS) within the past 5 years or immune system disorder? "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.	☐	☐

Personal physician ______________________________ ______________________________ (______) ______________
NAME ADDRESS TELEPHONE NO.

Employee's address ______________________________ Home phone (______) ______________

REMARKS AND ADDITIONAL INFORMATION FOR "YES" ANSWERS

If you answered "YES" to any medical questions above, please provide details below.

Ques. no.	First name	Description of illness, injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending physician or hospital *(Include zip.)*

IMPORTANT NOTICE TO APPLICANTS—PLEASE READ CAREFULLY

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau or any other organization to give Union Security Insurance Company or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to Union Security Insurance Company or its reinsurers to release any information to other life insurance companies as I may come in contact with.

I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. 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 to use and disclose protected health information.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I: 1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. 2) Authorize any required deductions from my earnings. 3) Designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. 4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. 5) Understand that I must be actively at work on the effective date, or coverage will be deferred until I return to work and that dependent coverage will not become effective while the dependent is in a hospital or similar facility. 6) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION.

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.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date ____________________ Signature ______________________________

Date ____________________ Spouse's signature *(if spousal coverage)* ______________________________

NOTICE REGARDING MEDICAL INFORMATION BUREAU
INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION

To properly underwrite applications and issue insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

In addition, we may obtain an investigative consumer report from an insurance support organization. If a report is prepared, upon request to your agent, you have the right to be personally interviewed in connection with the investigation. Also, upon proper request to Union Security Insurance Company, you may obtain a copy of the report.

Further, we or our reinsurers may obtain a report from and make a report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member for life or health coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply information contained in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of the information in its file. If the accuracy of the information is questioned, you may request that corrections be made by following the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112 (telephone 617.426.3660).

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding.

If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, Missouri 64108.