

Union Security Life Insurance Company of New York

**Home Office: 212 Highbridge Street
Syracuse, New York 13066**

**Mail to Administrative Office: PO Box 2981
Clinton, Iowa 52733-2981
T 888.901.6377**

Voluntary Term Life Insurance Employee Application

Please print.

Desired effective date of request _____

Failure to sign and date the application on the reverse and to accurately complete the questions on this enrollment request may affect the existence or amount of coverage.

| | | | | | |
|-------------------------|-------|-----|-------|--|---|
| Employer | | | | Policy/part no. | Certificate no. |
| Insured's name Last | | | First | MI | Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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 | MI | 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 the reverse side.

| | | | | | | | | | | | | | |
|--|--|----------------------------|-------|---------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| <p>Spouse coverage</p> <p>Name of the spouse _____</p> <p>Date of birth _____</p> <p>Amount elected \$ _____ <i>(Amount cannot exceed 50% of the employee's amount.)</i></p> <p>Has your spouse used tobacco products regularly in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If over the guaranteed issue amount, complete all health questions on the reverse side.</p> | <p>Dependent/child(ren) coverage <i>(If applying for dependent coverage, please complete below.)</i></p> <p><input type="checkbox"/> \$1,000 <input type="checkbox"/> \$4,000</p> <p>Child(ren)'s name(s)</p> <table border="0"> <tr> <td style="text-align: left;">Last <i>(if different)</i></td> <td style="text-align: center;">First</td> <td style="text-align: right;">Date of birth</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> | Last <i>(if different)</i> | First | Date of birth | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Last <i>(if different)</i> | First | Date of birth | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |

Refusal

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 Life Insurance Company of New York and that I can be turned down for coverage on the basis of my health.

Signature _____ Date _____

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 eligible dependents.

- | | | |
|---|--------------------------|--------------------------|
| | 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 <input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years: | | |
| a) Received or been advised to receive any medication, treatment, surgery, therapy, testing (except for HIV), 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Used any illegal drug? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever been treated or diagnosed as having: 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 or recurring diarrhea, fever or infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or your dependents ever been treated or diagnosed as having: 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 within the past 5 years or immune system disorder (except HIV)? | <input type="checkbox"/> | <input type="checkbox"/> |

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 or pregnancy, medication | 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:

1) I request the coverages I am eligible for under the policy issued by Union Security Life Insurance Company of New York to my employer named above. (2) Authorize any required deductions from my earnings. 3) I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. 4) I certify that the dates of birth, heights and weights on this form are correct to the best of my knowledge and belief. 5) I certify that I have answered all the health questions truthfully and have provided any additional information that was required to the best of my knowledge and belief. 6) I represent that I must be actively at work the number of hours specified in my contract/agreement to remain insured. 7) I authorize any doctor or health care entity, the Medical Information Bureau, employer, government or social agency, consumer reporting agency, Union Security Life Insurance Company of New York or other insurance companies, which has record of my health, my spouse's health or my dependents health, to furnish such information to Union Security Life Insurance Company of New York to determine my/their eligibility for insurance. 8) I 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. 9) This authorization will be valid for two years from the date shown below. 10) This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must enroll. Your coverage will not go into effect until the minimum requirement is met.

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

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 and information. 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.

We may obtain an investigative consumer report, based on interviews with neighbors, acquaintances, and business contacts, concerning the character, general reputation, personal characteristics, and mode of living of any individuals involved in this application. Upon written request, the Company will: furnish detailed information as to the nature and scope of any such investigations, inform you if it was requested, and if it was, also furnish you with the name and address of the reporting agency to whom the request was made. You may inspect and receive a copy of such report by contacting the reporting agency.

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.

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 LIFE INSURANCE COMPANY OF NEW YORK or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, 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 LIFE INSURANCE COMPANY OF NEW YORK 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 years from the date shown below. I know that I have the right to revoke this authorization at any time. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

Pursuant to Section 403(d) and Regular 95 of the New York State Insurance Law, **the following statement applies to our accident and health policies only:** "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 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's signature _____ Date _____

Spouse's signature (if spousal coverage) _____ Date _____

NOTICE REGARDING MEDICAL INFORMATION BUREAU

One of the prime objectives of Union Security Life Insurance Company of New York is to provide Insurance at low cost on an equitable basis to all policyholders. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes a fair share of the cost. In considering application for insurance, information from various sources must, therefore, be considered. These include the results of the proposed insured's physical examination, if required, and any reports we may receive from doctors and hospitals who have attended the proposed insured.

Information regarding factors affecting insurability will be treated as confidential. We may, however, make a brief report thereon 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 application is made to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with any information it may have in its file.

Upon receipt of a request, the Bureau will arrange disclosure of any information it may have in the file of the person making such a request. If the accuracy of the information in the Bureau's file is questioned, the Bureau may be requested to make a correction by following the same procedure as those set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617.426.3660.

The purpose of the Bureau is to protect the policyholders of its members from bearing the extra mortality cost created by those who would conceal facts relevant to their insurability. The Bureau is not a repository of medical reports from hospitals and physicians, and information in the Bureau file does not reveal whether applications for insurance are accepted, rated, or declined.

We may also release information in our file to our reinsurers and to other insurance companies to whom application is made for life or health insurance, or to whom a claim for benefits is submitted.

NOTICE CONCERNING CONSUMER REPORTS

An investigative consumer report may be obtained, based on interviews with neighbors, acquaintances, and business contacts, concerning the character, general reputation, personal characteristics, and mode or living of any individuals involved in this application. Upon written request, the Company will furnish detailed information as to the nature and scope of any such investigations, inform you if it was requested, and if it was, also furnish you with the name and address of the reporting agency to whom the request was made.

You may inspect and receive a copy of such investigative consumer report by contacting the reporting agency.

AUTHORIZATION TO FURNISH INFORMATION

By this form or a copy of it, I authorize any physician, practitioner, hospital, clinic, health care provider, health facility, medical or medically related facility, the Medical Information Bureau, employer, government or social agency, consumer reporting agency, or insurance company which possesses any records or knowledge as to diagnosis, treatment, or prognosis regarding me or my minor children to furnish such information to Union Security Life Insurance Company of New York, or its reinsurers upon presentation of this authorization or a photocopy thereof. This authorization is for the release of confidential HIV-related information in relation to diagnosis and/or treatment, as well as the release of information about drugs, alcoholism, and mental illness. This authorization does not apply to drug and alcohol records otherwise protected under applicable Federal regulations. This authorization will be valid for two years from the date shown previously. I have the right to revoke this authorization at any time, in writing subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.