

Employee Application



ISSUE

Check one – Employer Use

- Initial Employee
 New Employee
 Change

EMPLOYEE INFORMATION—Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name (<i>last, first, initial</i>) Doe, Jane		Employer Sample Group			Employment location	
Group policy/participant no.		Account no.	Cert. no.	Employee SSN	Employee birthdate 06/08/1964	
Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Job title or position Employee	Employee hire date	No. hours Per week 40.0	ANNUAL Earnings \$30,000.00		Married <input type="checkbox"/> Yes <input type="checkbox"/> No
Address		City	State	Zip		

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

DEPENDENT INFORMATION—Required if Dependent coverage applies

Name (Last Name, First Name)	SSN	Date of Birth	Gender	Relationship

VOLUNTARY LIFE / AD&D INSURANCE—Employee Coverage

Benefit	MONTHLY PREMIUM		Benefit	MONTHLY PREMIUM	
	Life	Life/AD&D		Life	Life/AD&D
<input type="checkbox"/> \$60,000	12.48	14.28	<input type="checkbox"/> \$30,000	6.24	7.14
<input type="checkbox"/> \$50,000	10.40	11.90	<input type="checkbox"/> \$20,000	4.16	4.76
<input type="checkbox"/> \$40,000	8.32	9.52	<input type="checkbox"/> Other \$ _____	_____	_____

Refuse Employee Voluntary Life
 Refuse Employee Voluntary AD&D

VOLUNTARY LIFE INSURANCE – Spouse Coverage

Benefit	MONTHLY PREMIUM		Benefit	MONTHLY PREMIUM	
	Life	Life		Life	Life
<input type="checkbox"/> 25,000	2.60		<input type="checkbox"/> 10,000	1.04	
<input type="checkbox"/> 20,000	2.08		<input type="checkbox"/> 5,000	0.52	
<input type="checkbox"/> 15,000	1.56		<input type="checkbox"/> Other \$ _____	_____	_____

Refuse Spouse Voluntary Life

Union Security Insurance Company

Mail to: Assurant Employee Benefits P.O. BOX 2939 Clinton, IA 52733-2939

Form 61 (06/2003)

ISSUE

Employee name Doe, Jane		Employer Sample Group
Group policy/participant no.	Account no.	Cert. no.

VOLUNTARY LIFE INSURANCE – Child coverage

<u>MONTHLY PREMIUM</u>					
Benefit	Life	Benefit	Life	Benefit	Life
<input type="checkbox"/> 10,000	1.82	<input type="checkbox"/> 5,000	0.91	<input type="checkbox"/> 1,000	0.18
<input type="checkbox"/> Refuse Child Voluntary Life					

BENEFICIARIES

Last name	First	MI	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.

1) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee Life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 5) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

VOLUNTARY LONG TERM DISABILITY INSURANCE

<u>BENEFIT</u>	<u>MONTHLY PREMIUM</u>
<input type="checkbox"/> \$2,000 Maximum Benefit	\$13.00
<input type="checkbox"/> \$500 Minimum Benefit	\$3.25
<input type="checkbox"/> Other Benefit \$ _____	\$ _____
<input type="checkbox"/> Refuse Voluntary Long Term Disability	

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) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

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.

Employee's signature _____ Date _____

Employee Health Statement

Employee name <i>(last, first, initial)</i> Doe, Jane			Employer Sample Group	
Group policy/participant no.	Account no.	Cert. no.	Employee SSN	Employee birthdate

New Enrollee Annual Enrollment Life Event-Type/Date _____

Please answer the following questions. If you are applying for dependent coverage, please answer all questions for your eligible dependents. Applicant's Height _____ Weight _____ Spouse's Height _____ Weight _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you or your dependents gained or lost 10 or more pounds in the past 12 months?
If yes, how much _____ | <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, 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 or recurring diarrhea, fever or infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or your dependents pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or your dependents used tobacco, in any form in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your dependents ever had, been medically diagnosed, treated or been advised to seek treatment 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 immunodeficiency 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. | <input type="checkbox"/> | <input type="checkbox"/> |

Name, address and telephone _____
number of personal physician _____

Employee's address _____ Daytime phone (_____) _____

**If you answered "YES" to any questions, please provide details in REMARKS below.
Elections are not valid without a signature at the end of this application.**

REMARKS

If you answered "Yes" to any medical questions above, please provide details below:

Question 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 (including zip)

Employee name Doe, Jane		Employer Sample Group
Group policy/participant no.	Account no.	Cert. no.

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.

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.

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.

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 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) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

This will certify that I HAVE read and understand the above important notice.

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.

Employee's signature _____ Date _____

Spouse's signature (if spouse coverage elected) _____ Date _____