Employee Dental Application—Oregon

ASSURANT Employee Benefits

G. O. no. ________

Group policy/participant no.	Account no.	Cert. no.	Employer	Employment location/phone no.

Employee name Last First Initial	Full-time employ. date Mo. Day Yr.	Part-time employ. date Mo. Day Yr.	Sex ☐M ☐F	Married ☐Yes ☐No	Children ☐Yes ☐No

Employee date of birth Month Day Year	No. hrs. per week ________	Job title or position	State of residence	Employee Soc. Sec. no.

Status: *(If status area is not completed, we consider the employee to be active.)*

☐ Retired ☐ Continuation ☐ Leave of absence ☐ Other ________

Reason ________ Date ________

Please mark **X** in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: ☐ Dental

Dependent: ☐ Dental **Please** mark **X** in box before the dependents to be covered: ☐ Spouse ☐ Children

If spouse coverage is being applied for, complete the following.

Name of Spouse	Date of Birth Month Day Year	Social Security No.	Employer	Current Dental Insurance Carrier

Write in the names and dates of birth of children to be covered *(subject to plan provisions)*.

____

____

Were you covered under another dental plan within the last 31 days? ☐ No ☐ Yes

If "Yes," termination date ________ Reason for termination of other coverage ________

***NOTE—** Coverages not specifically elected will not be made effective, even if not refused.
ELECTIONS NOT VALID WITHOUT SIGNATURE.

If coverage is refused, provide the reason for refusal. ________

IMPORTANT NOTICE TO APPLICANT — PLEASE READ CAREFULLY

My signature on this application certifies that I:

(1) Apply for the coverage designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverage has been refused, I am not entitled to benefits under that coverage and that if I want to apply later, I understand I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy. (3) Authorize any required deductions from my earnings. (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 the number of hours specified in my policy/participation agreement to remain insured. (6) Understand that I have the right to select any dental care provider of my choice. (7) Understand that the dental plan includes a pre-estimate provision, that will advise me in advance of the benefits I may be eligible for if the procedure is performed. (8) When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

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.

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

Signature ________ Date ________

Union Security Insurance Company
Mail to: **Assurant Administrative Office** P.O. Box 981624 El Paso, Texas 79998-1624

Form 10 (12/98)

KC4035AOR (05/2012)
NF