Dental PPO

Good news about dental benefits for employees of ABC Company

Why is dental health so important?
Regular dental care does more than just improve smiles. Along with good oral hygiene, it can help you and your family lower your chances of serious health problems.

- Gum disease has been linked to a 50 percent rise in pancreatic and kidney cancer risk and a 30 percent increase in blood cell cancers.\(^1\)
- Research has shown, and experts agree, that there is an association between periodontal diseases and other chronic inflammatory conditions, such as diabetes, cardiovascular disease and Alzheimer’s disease.\(^2\)

How can I get the coverage I need?
Dental insurance offers you a convenient way to get regular dental care and can possibly help prevent life-threatening health problems. And through your employer, you can get this protection at an affordable group rate.

How do I know I’m eligible to participate in this plan?
You can participate in this plan if you are a full-time employee of the policyholder or an associated company, and work in the United States. Full-time means working 20 hours or more per week. Temporary or seasonal workers are not eligible.

Key Advantages of This Plan

- Your plan includes our Lifetime of Smiles\(^\circledR\) program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer.
- Assurant\(^\circledR\) Dental Network the PPO network for your plan, includes 100,000+ unique dentists, and offers you more options to help save on fees and can make your annual maximum go even further.\(^3\)

IMPORTANT:
Coverage for eligible employees will begin October 1, 2013. You must sign up by the Initial Enrollment Deadline, or forfeit the opportunity until the next plan anniversary date.

\(^1\)Journal of Periodontology, January 2011.
\(^3\)The PPO network for your plan includes dentists contracted with Dental Health Alliance, L.L.C.\(^\circledR\) (DHA\(^\circledR\)) and dentists under access arrangements with other dental networks.

Assurant Employee Benefits is the brand name used for insurance products underwritten and issued by Union Security Insurance Company.
How does my plan work?
Your plan covers a range of services for you and your family. Highlights of your benefits can be found below. Benefits are paid after any applicable deductible has been met, up to the annual maximum. For more specific information, please ask to see the certificate of insurance.

Why is Dental insurance a smart choice?
Compare the annual cost of your Dental insurance with paying your dental expenses yourself:

National Average Retail charge\(^1\) for dental procedures:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost</th>
<th>Twice yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cleaning</td>
<td>$86</td>
<td>$172</td>
</tr>
<tr>
<td>Oral Examination</td>
<td>$47</td>
<td>$94</td>
</tr>
<tr>
<td>Bitewing x-rays</td>
<td>$58</td>
<td></td>
</tr>
</tbody>
</table>

Total annual cost for preventive care $324

Other services you may need:

- Fluoride treatment $30
- One surface filling $131
- Root canal $348
- Crown $959
- Gum scaling $207

\(^1\)Average Retail Costs were determined by Assurant Employee Benefits national claims analysis for the year 2013. The costs represent a mean average rounded to the nearest dollar representing what you may pay without plan services.

Your Cost for Dental Insurance

<table>
<thead>
<tr>
<th>BI-WEEKLY Cost for Dental Insurance</th>
<th>High Plan Cost*</th>
<th>Low Plan Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>For you</td>
<td>$26.10</td>
<td>$13.05</td>
</tr>
<tr>
<td>For you and your spouse</td>
<td>$44.12</td>
<td>$25.22</td>
</tr>
<tr>
<td>For you and your children</td>
<td>$45.68</td>
<td>$26.79</td>
</tr>
<tr>
<td>For you and your family</td>
<td>$72.88</td>
<td>$34.11</td>
</tr>
</tbody>
</table>

* Your actual cost may vary depending upon your employer's contribution towards the cost of the plan.

How can using a network dentist help lower my costs?
You are free to use the dentist or specialist of your choice. However, when you choose a dentist in the Assurant\(^\circledR\) Dental Network, your plan's PPO network, you may save money. Using a network dentist may lower your out-of-pocket costs and can make your annual maximum go further.

The dental network for your plan includes 100,000+ unique dentists contracted with Dental Health Alliance, L.L.C.\(^\circledR\) (DHA\(^\circledR\)) and dentists under access arrangements with other dental networks. To find a dentist in your area, or to nominate your dentist to participate in our network, go to www.assurantermployeebenefits.com, select For Members, then Find a dentist, or call Customer Service at 888.901.6377.

What are my plan options?
Your employer is offering you a choice of two plans. Please review the information on the following pages and choose the one plan that best fits your needs.
### The High Plan

#### Plan Features

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>In Network</th>
<th>Out-of-Network</th>
<th>Calendar Year Maximum</th>
<th>In Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person, per calendar year</td>
<td>$50</td>
<td>$50</td>
<td></td>
<td>$1000</td>
<td>$1000</td>
</tr>
<tr>
<td>Waived for Class I Preventive</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family limit of 3 individuals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class I Preventive</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II Basic</td>
<td>90%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class III Major</td>
<td>60%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Orthodontia Benefits
- Not included

### Class I Preventive Dental Services, Including:
- Oral evaluations – once in any 6-month period
- Routine dental cleanings – once in any 6-month period
- Fluoride treatment – once in any 6-month period. *Only for children under age 14*
- Sealants – no more than once per tooth per person, only for permanent molar teeth. *Only for children under age 14*
- Genetic test for susceptibility to oral diseases
- Bitewing x-rays – once in any 12-month period
- Panoramic or complete series x-rays – once in any 60-month period
- Space maintainers. *Only for children under age 19*

### Class II Basic Dental Services, Including:
- New fillings
- Replacement fillings – once in any 24-month period per filling
- Simple extractions, removal of exposed roots, incision and drainage
- Complex extractions
- Endodontics (includes root canal therapy)
- Endodontic retreatment (covered after 24 months have passed from initial treatment)
- Complex oral surgery
- Biopsy (including brush biopsy)

### Class III Major Dental Services, Including:
- Fixed partial dentures (bridges) and full and partial dentures (removable)
- General anesthesia and IV sedation when medically required
- Stainless steel crowns. *Only for children under age 19*
- Inlay, onlay, and crown restorations

### Waiting Periods

For a complete description of services and waiting periods, please review the certificate of insurance. If you were covered under your employer’s prior plan the wait will be waived for any class of service covered under the prior plan and this plan.
- No waiting period for preventive or basic services.
- 12-months for major services.
The Low Plan

Plan Features

<table>
<thead>
<tr>
<th>Deductible Feature</th>
<th>In Network</th>
<th>Out-of-Network</th>
<th>Calendar Year Maximum</th>
<th>In Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per person, per calendar year</td>
<td>$50</td>
<td>$50</td>
<td>$1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waived for Class I Preventive</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family limit of 3 individuals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible In Network</td>
<td>$1000</td>
<td>$1000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible Out-of-Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance Percentage</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Orthodontia Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I Preventive</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td>Not included</td>
</tr>
<tr>
<td>Class II Basic</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class III Major</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Orthodontia Benefits

Class I Preventive Dental Services, Including:
- Oral evaluations – once in any 6-month period
- Routine dental cleanings – once in any 6-month period
- Fluoride treatment – once in any 6-month period. Only for children under age 14
- Sealants – no more than once per tooth per person, only for permanent molar teeth. Only for children under age 14
- Genetic test for susceptibility to oral diseases
- Bitewing x-rays – once in any 12-month period
- Panoramic or complete series x-rays – once in any 60-month period
- Space maintainers. Only for children under age 19

Class II Basic Dental Services, Including:
- New fillings
- Replacement fillings – once in any 24-month period per filling
- Simple extractions, removal of exposed roots, incision and drainage
- Complex extractions
- Minor gum disease treatment: (minor periodontics)
  - Scaling and root planing – once in any 24-month period per area
  - Localized delivery of antimicrobial agents
  - Periodontal maintenance – once in any 6 consecutive months
- Major gum disease treatment: (major periodontics)
  - Gingivectomy, osseous surgery, other major periodontic procedures – once in any 36-month period per area
- Stainless steel crowns. Only for children under age 19
- Inlay, onlay, and crown restorations

Class III Major Dental Services, Including:
- Fixed partial dentures (bridges) and full and partial dentures (removable)
- Endodontics (includes root canal therapy)
- Endodontic retreatment (covered after 24 months have passed from initial treatment)
- Complex oral surgery
- Biopsy (including brush biopsy)
- General anesthesia and IV sedation when medically required
- Major gum disease treatment: (major periodontics)
  - Gingivectomy, osseous surgery, other major periodontic procedures – once in any 36-month period per area
- Stainless steel crowns. Only for children under age 19
- Inlay, onlay, and crown restorations

Waiting Periods

For a complete description of services and waiting periods, please review the certificate of insurance. If you were covered under your employer’s prior plan the wait will be waived for any class of service covered under the prior plan and this plan.
- No waiting period for preventive or basic services.
- 12-months for major services.
Who are eligible dependents?
Those qualified to be covered under your dental plan include your spouse and children less than age 26. See your certificate or group insurance policy for additional eligibility details.

Dental plan provisions, limitations and exclusions

Benefit Adjustments
Benefits will be coordinated with any other dental coverage. Under the Alternate Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the charge for any dental treatment is expected to exceed $300, it is recommended that a dental treatment plan be submitted to Assurant Employee Benefits for review before treatment begins.

Late Entrant Limitation
If you apply for dental insurance more than 31 days after a covered person first becomes eligible, the person is a late entrant. The benefits for the first 12 months of coverage for late entrants will be limited as follows:

<table>
<thead>
<tr>
<th>Time Insured Continuously Under the Policy</th>
<th>Benefits Provided for Only These Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 months</td>
<td>Preventive Dental Services</td>
</tr>
<tr>
<td>At least 6 months but less than 12 months</td>
<td>Preventive and all Basic Dental Services</td>
</tr>
<tr>
<td>At least 12 months</td>
<td>Preventive, Basic and Major Dental Services</td>
</tr>
</tbody>
</table>

We will not pay for any treatment that is started or completed during the late entrant limitation period.

Other Important Plan Provisions
Benefits are not payable for the following, unless such insurance is provided under the list of covered dental services:

- Treatment or an appliance which is not dentally necessary, is experimental or temporary in nature, or does not have uniform professional endorsement, treatment related to procedures that are part of a service but are not reported as separate services, reported in a treatment sequence that is not appropriate or misreported or that represent a procedure other than the one reported, appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting, any treatment or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension, the alteration or restoration of occlusion, except for occlusal adjustment in conjunction with periodontal surgery, bite registration, bite analysis, attrition or abrasion, replacement of a lost or stolen appliance or prosthesis, educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions, completion of claim forms or missed dental appointments, personal supplies or equipment, including but not limited to water piks, toothbrushes, floss holders, or athletic mouthguards, administration of nitrous oxide or any other agent to control anxiety, treatment for a jaw fracture, treatment provided by a dentist, dental hygienist, or dentist who is an immediate family member or a person who ordinarily resides with a covered person, an employee of the policyholder, or a policyholder, hospital or facility charges for room, supplies or emergency room expenses or routine chest x-rays and medical exams prior to oral surgery, treatment provided primarily for cosmetic purposes, treatment which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years, crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which do not have extensive decay or fracture and can be restored with an amalgam or composite resin filling, any treatment required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures, treatment for implants, implant abutments, implant supported prosthetics (crown, fixed partial denture, dentures) or any other services related to the care and treatment of the implant, treatment for the prevention of bruxism (grinding of teeth), orthodontic treatment, treatment performed outside the United States, except for emergency dental treatment (the maximum benefit payable to any person during a benefit year for covered dental expenses related to emergency dental treatment performed outside the United States is $100), treatment or appliances at which are covered under any Workers' Compensation Law, Employer's Liability Law or similar law (a person must promptly claim and notify us of all such benefits), treatment for which a charge would not have been made in the absence of insurance, treatment for which a covered person does not have to pay, except when payment of such benefits is required by law and only to the extent required by law.

State variations can exist; please contact Assurant Employee Benefits for additional information.
Voluntary Life

ABC Company announces Life insurance protection for its employees

Proposed Effective Date: 10/01/2015

Voluntary Group Term Life and Accidental Death and Dismemberment (AD&D) coverage is available to you for purchase through payroll deduction. Voluntary Life insurance can be a way to protect your family in the event of your death, particularly if you have financial obligations such as a mortgage or children in college.

The plan your employer has selected includes the following features:

Eligibility
♦ You are eligible to participate in the plan if you are a full-time employee of the policyholder or an associated company,
  ➢ who is at active work, and
  ➢ who is working in the United States of America, except any temporary or seasonal worker.
  ➢ Any other requirements set by your employer must also be met. “Full-time” means working at least 20 hours per week.

♦ Dependent Life insurance is available for eligible dependents, including your lawful spouse (if not disabled or hospital confined on the effective date) and unmarried children (if not hospital confined) from live birth to age 19, or to age 25 if a full-time student. The hospital confinement exception does not apply to a child born while dependent insurance is in effect.

♦ If you and your spouse work for the same employer and are both eligible for this insurance as employees, you cannot cover each other as dependents, and only one of you may insure any dependent children.

Voluntary Life Schedule Amounts
♦ Life insurance coverage is available in $10,000 units from a minimum of $20,000 to a maximum of $250,000, not to exceed 5 times your basic annual earnings.

♦ At age 70, we will reduce by 33% the original Life insurance amount, rounded to the next higher $10,000, if not already an exact multiple of $10,000; at age 75, reduce by 33% of the inforce amount, similarly rounded. The reduced amount will not be less than $20,000.

♦ If you elect coverage for yourself, you can buy up to 50% of that amount for your spouse in $5,000 units to a maximum of $125,000. If you elect child coverage, your children are eligible to be covered for $1,000, $5,000 or $10,000 each. The amount of insurance for an eligible dependent cannot be more than 50% of your Life insurance amount.
Accidental Death and Dismemberment Insurance (AD&D)
♦ The AD&D benefit, if elected, equals the employee or dependent Life amount, to a maximum of $250,000. You must elect AD&D for yourself in order to elect AD&D for your dependents. AD&D provides 24-hour coverage and a benefit in the event of your loss of life, limb or eyesight as a direct result of an accident, provided the loss occurs within 365 days of the accident. The coverage includes:
  ➢ A Higher Education Benefit that pays an additional $3,000 per year for up to 4 consecutive years for eligible dependent students. (Applies to Employee AD&D Only.)
  ➢ An Automobile Accident Benefit that pays an additional 20% of the scheduled AD&D benefit, to a maximum of $100,000, if the covered person dies from an automobile accident injury while wearing a seat belt, provided an AD&D benefit is payable. Limitations and exclusions may apply.
♦ AD&D Exclusions - We will not pay benefits if the loss results directly or indirectly from war; riot or insurrection; service in the armed forces; physical or mental disease; infection (except pyogenic infection that occurs from an accidental wound); assault or felony committed by the covered person; suicide or attempted suicide; intentionally self-inflicted injury; the use of any drug, unless it is used as prescribed by a doctor; or your intoxication, including but not limited to operating a motor vehicle while you are intoxicated.

Proof of good health requirements
♦ The Guarantee Issue amount for an employee is $130,000; a spouse is $50,000; a child is $10,000.
♦ "Guarantee Issue" means the amount of coverage you can purchase without answering proof of good health questions. Guarantee Issue amounts apply to timely eligible applicants. A timely applicant is one who applies for coverage within 31 days from the date that all eligibility requirements are met. If you decline Voluntary Life coverage, you may be required to provide proof of good health to become insured.

Additional Features
♦ If you become disabled, your premiums may be waived to the earliest of age 65, recovery or retirement if disabled prior to age 60. If you become disabled at age 60 through 64, the waiver of premium will be to the earliest of one year, age 65 or retirement. You may be considered disabled for Life insurance if you are considered disabled under our Long-Term Disability policy. Any time Life insurance is continued under the Waiver of Premium, AD&D insurance will also be continued (and the premium waived) for up to 1 year from the date of disability. Limitations and exclusions apply.
♦ An Accelerated Benefit pays up to 80% of the Life benefit to a maximum of $250,000 in the event of a life-threatening medical condition where there is a life expectancy of 12 months or less. An Accelerated Benefit may also be available for an insured spouse. Limitations and exclusions apply.
♦ Plan portability allows you to continue coverage for up to 3 years after terminating current employment. Limitations and exclusions apply.
♦ A Conversion Privilege allows you to convert to an individual policy if any or all of your Life insurance ends while you are insured under our group Life policy. AD&D coverage is not eligible for conversion. Limitations and exclusions apply.

For insureds or dependents who commit suicide within the first year after the effective date of their coverage, the only benefit amount payable is a refund of the amount of the insured's contributions. This coverage has limitations and exclusions. Not all plan provisions or options are available in all states. In addition, some states require modifications to the benefits described here. For complete details, please contact your company's benefits representative or refer to your benefit booklet. This highlight sheet provides a brief description of coverage. In the event that a discrepancy exists, the policy provisions will prevail. We can cancel the policy after giving the policyholder 31 days written notice.
Employee Application

Please print clearly in blue or black ink.

RENEWAL

Check one – Employer Use
☐ New Employee       ☐ Change       ☐ COBRA

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.

<table>
<thead>
<tr>
<th>Employee name (last, first, initial)</th>
<th>Employer</th>
<th>Employment location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group policy/participant #</th>
<th>Account # or Bill Name</th>
<th>Group Name</th>
<th>Cert. #</th>
<th>Employee SSN</th>
<th>Employee birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Job title or position</th>
<th>Employee hire date</th>
<th># hours</th>
<th>Earnings $</th>
<th>Married</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
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</tr>
</tbody>
</table>

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

DEPENDENT INFORMATION—Required if Dependent coverage applies

<table>
<thead>
<tr>
<th>Name (Last Name, First Name)</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE — Coverage not elected will be assumed refused even if not specifically refused

Employee Choice Life Benefits – You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

<table>
<thead>
<tr>
<th>Accept</th>
<th>Refuse</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Employee Voluntary Life - Amount ______</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employee Matching Voluntary AD&amp;D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse Life - Amount ______</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse Matching Voluntary AD&amp;D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child(ren) Voluntary Life - Amount ______</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child(ren) Matching Voluntary AD&amp;D</td>
</tr>
</tbody>
</table>
DENTAL BENEFITS— You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Low Plan Option:

<table>
<thead>
<tr>
<th>Accept</th>
<th>Refuse</th>
<th>Coverage</th>
<th>Accept</th>
<th>Refuse</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Employee</td>
<td></td>
<td></td>
<td>Employee + Child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employee + Spouse</td>
<td></td>
<td></td>
<td>Employee + Family</td>
</tr>
</tbody>
</table>

High Plan Option:

<table>
<thead>
<tr>
<th>Accept</th>
<th>Refuse</th>
<th>Coverage</th>
<th>Accept</th>
<th>Refuse</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Employee</td>
<td></td>
<td></td>
<td>Employee + Child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employee + Spouse</td>
<td></td>
<td></td>
<td>Employee + Family</td>
</tr>
</tbody>
</table>

☐ Refuse Dental Benefits

BENEFICIARIES – APPLIES TO ALL COVERAGES FOR WHICH A BENEFICIARY DESIGNATION IS REQUIRED

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>MI</th>
<th>Relationship*</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
</table>

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 coverage elected on this form for which a beneficiary designation is required. 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 or you want to specify a beneficiary by coverage, please contact Union Security Insurance Company for the appropriate forms.
### 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. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant Limitation period specified in the policy. 
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. 
7. Understand that I have the right to select any dental care provider of my choice. 
8. 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. 
9. Understand that coverages include waiting periods, limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits. 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 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 __________________

### AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agent Name: ________________________________

Agent/Broker Name: ________________________________

Enroller Name: ________________________________
<table>
<thead>
<tr>
<th>Employee name</th>
<th>Employer</th>
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<tr>
<td>Group policy/participant no.</td>
<td>Account no.</td>
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Employee Health Statement for Voluntary and Worksite Coverage

Employee name (last, first, initial)  

Employer

Group policy/participant no.  Account no.  Cert. no.  Employee SSN  Employee birthdate

☐ New Enrollee  ☐ Annual Enrollment  ☐ Life Event-Type/Date __________________________

Answer the following questions based upon the coverage for which you are applying for you and your dependents. For CANCER, answer questions 1 and 2 only. For CRITICAL ILLNESS, HOSPITAL INDEMNITY or LIFE, answer questions 1 through 6.

Applicant Height:______  Weight:________   Spouse Height: ______   Weight: ______

YES   NO

1. Have you or your dependents used tobacco, in any form in the past 12 months?

2. In the last 10 years, have you or your dependents been diagnosed, treated, or received advice to seek treatment for any tumor, malignancy or any type of internal cancer, melanoma, leukemia, lymphoma, sarcoma or Hodgkin's disease or been diagnosed with an elevated PSA, abnormal Pap or colposcopy? Have you had a hysterectomy or prostate removal?

3. In the past 5 years, have you or your dependents been hospitalized, undergone any inpatient or outpatient surgery or procedure or been advised to be hospitalized or have surgery by a physician or medical provider?

4. In the past 12 months, have you or your dependents been prescribed or advised to take prescription medication?

5. Have you or your dependents ever been diagnosed, received treatment, or been advised to seek treatment for any mental, psychiatric, emotional or eating disorder, alcoholism, alcohol abuse, prescription or illegal drug abuse? Have you or your dependents ever been arrested for DUI, illegal drug possession or use?

6. Have you or your dependents ever been diagnosed, received treatment, or been advised to seek treatment for: (circle all that apply and provide details below) diabetes, heart or vascular disease, heart attack, blood disorder, stroke, high blood pressure, asthma, emphysema or other lung disorder, kidney disease, liver disease, gallstones, pancreas disorder, colitis, Crohn's disease, glaucoma, seizures, lupus or autoimmune disorder, multiple sclerosis, Parkinson's, Muscular dystrophy or any paralysis, arthritis, disorder of the back, neck, spine, or joint, including hip or knee? Have you or your dependents ever been diagnosed, treated, or advised to seek treatment for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)?

Note: “Disorder” is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state or structure.

REMARKS

If you answered "Yes" to any medical questions above, please provide details below: Sign and date the form on back.

<table>
<thead>
<tr>
<th>Question no.</th>
<th>First name</th>
<th>Description of illness, injury or pregnancy, medication and treatment</th>
<th>Duration (dates) &amp; no. of episodes</th>
<th>Residual effects</th>
<th>Name and address of attending Physician or hospital (including zip)</th>
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Union Security Insurance Company
Mail to: Assurant Employee Benefits Attn: Worksite, P.O. BOX 419596, Kansas City, MO 64141-6596
Form 73 (04/2009)
IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

AUTHORIZATION TO RELEASE INFORMATION: To properly underwrite applications, determine eligibility for coverage and issue insurance policies on an equitable basis, we must obtain information about you. 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.

By signing below, I authorize any provider of medical services, physicians, or other medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager or any pharmacy related services entity, insurance company, employer, Medical Information Bureau, consumer reporting agency, or other individual or entity to give Union Security Insurance Company or its reinsurers any information regarding my medical or health history. Such information includes but is not limited to any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or pharmacy records.

I understand that I have the right to refuse to sign this authorization but if I refuse, Union Security Insurance Company may refuse to consider my application for enrollment. I understand that a photocopy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is voluntary and that I may revoke it at any time by writing Union Security Insurance Company, P.O. Box 419052, Kansas City, MO 64141-6052, Attn: Privacy Office. Such revocation will not affect any action taken by Union Security Insurance Company prior to receipt of the revocation. If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.

The authorization is effective from the date signed below until the earliest of denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Union Security Insurance Company, but at no time longer than 30 months.

Federal law requires that we inform you that the information which we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. However, be assured that disclosure will be strictly limited to that which is reasonably necessary and we will comply with all federal and state privacy and security laws and regulations. You have the right to gain access to and request correction of information contained in our files.

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. (5) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

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 ___________________________