Employee Application



						G. O. no
Group policy/participant no.	Account no.	Cert. no.	Employer		Emp	loyment location/phone no.
Employee name (last, first, initial)				employ. date Day Year	Employee date of birth Month Day Year	
Sex Married ☐ M ☐ Yes ☐ F ☐ No	Children □ Yes □ No	Earnings Employee Soc. Sec. no.				
Job title or position		☐ Weekly ☐ Monthly ☐ Yearly ☐ Other			State of residence	
Status: (If status area is not co	mpleted, we co	nsider the e	mployee to b	e active.)		
☐ Retired ☐ Continuation ☐	Leave of absen	ce □ Other	•			
Reason					Date	
Please mark X in box before the	e coverages yo	u are applyii	ng for if you a	re eligible fo	or them under	your employer's plan:
Employee: □ Life □ Accide	ntal Death & Di	smemberme	ent 🗆 Optio	nal Addition	al Life Amt	
☐ Short Term Dis	ability □Long	Term Disab	ility Optiona	l Amount:	□STD □L	TD Amt
□ Dental						
Dependent: □ Life □ Dental If spouse coverage is being ap	plied for, comp			endents to b	e covered:	☐ Spouse ☐ Children Current Dental
Date of Birth Name of Spouse Month Day Year		Social Security No. Employer				Insurance Carrier
Write in the names and dates of	of birth of childr	en to be cov	ered (subject	t to plan pro	visions).	
Were you covered under anoth	er dental plan v	vithin the las	t 31 days? [□Yes □N	0	
If "Yes," termination date Note — Coverages not specific ELECTIONS NOT VAL Write in any coverages being re	ally elected will ID WITHOUT SI	not be made IGNATURE.	e effective, ev	•		
BE	NEFICIARIES	(Please read	d information	below befor	e completing.)
Last name First	MI Rela	ationship*	☐ Primary ☐ Secondar	-у		
			☐ Primary ☐ Secondar	·y		
			□ Primary□ Secondar	v		

^{*}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) If primary/secondary election is not noted, the beneficiary will be considered primary. 3) 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. 4) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

IMPORTANT NOTICE TO APPLICANTS—PLEASE READ CAREFULLY

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 the 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 my 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) 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.

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

Signature		
	Signature	Date