

Employee Application



Group policy/participant no.		Account no.	Cert. no.	Employer	Employment location/phone no.
Employee name (last, first, initial)			Part-time employ. date Month Day Year	Full-time employ. date Month Day Year	Employee date of birth Month Day Year
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No	Earnings _____ <input type="checkbox"/> Hourly No. hrs. per week _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____		Employee Soc. Sec. no.
Job title or position			State of residence		
Status: (If status area is not completed, we consider the employee to be active.)					Employee home address and phone no.
<input type="checkbox"/> Retired <input type="checkbox"/> Continuation <input type="checkbox"/> Leave of absence <input type="checkbox"/> 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 Coverage:	Amount of Insurance		Amount of Insurance
<input type="checkbox"/> Base Life & AD&D	\$ _____	<input type="checkbox"/> Additional Contributory Life	\$ _____
<input type="checkbox"/> Long Term Disability	\$ _____	<input type="checkbox"/> Alternate Long Term Disability	\$ _____
<input type="checkbox"/> Short Term Disability	\$ _____	<input type="checkbox"/> Alternate Short Term Disability	\$ _____

Dependent Coverage: **Please** mark **X** in box before the dependents to be covered:

Spouse \$ _____ Children (less than 6 months) \$ _____ Children (6 months or older) \$ _____

Note—Coverage not specifically elected will not be made effective, even if not refused.
ELECTIONS NOT VALID WITHOUT SIGNATURE ON PAGE 2.

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

	Date of Birth		
Name of Spouse	Month Day Year	Social Security No.	Employer

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

Write in any coverages that you/your dependents are refusing and the reason for refusal.

BENEFICIARIES

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

**GARDNER
& WHITE**
(Administrator)

Union Security Insurance Company

Mail to: **Assurant Employee Benefits** 201 W. 103rd Street Suite 505 Indianapolis IN 46290
Form 10 (12/98)

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) 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 _____