

Extended Employee Application



(Please complete the health questions on the second page of this 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	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
Employee date of birth Month Day Year	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 _____	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.) <input type="checkbox"/> Retired <input type="checkbox"/> Continuation <input type="checkbox"/> Leave of absence <input type="checkbox"/> Other _____ Reason _____ Date _____				Employee home address and phone no.		

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:	Guaranteed Amount of Insurance	Amount That Requires Underwriting
<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 THE SECOND PAGE.

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

Name of Spouse _____ Date of Birth _____
 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

HEALTH QUESTIONS

Please answer the following questions. If you answer "YES" to any questions, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your eligible dependents.

- Applicant:** Height _____ Weight _____ **Spouse:** Height _____ Weight _____ **Yes No**
1. Have you (or your dependents) gained or lost 10 or more pounds during the past 12 months?
If "Yes," how much _____
 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 drugs?
 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?
 4. Are you (or your dependents) pregnant?
 5. Have you (or your dependents) used tobacco, in any form in the past 12 months?
 6. In the past 5 years, have you (or your dependents) ever had, been medically diagnosed, treated or been advised to seek treatment for: back, neck or joint disorder; lung disorder; heart disease or disorder; mental, nervous or eating disorder; or immune system disorder?
 7. In the past 10 years, have you (or your dependents) ever had, been medically diagnosed, treated or been advised to seek treatment for: arthritis; asthma; emphysema; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke; depression; psychological counseling; seizures; or acquired immunodeficiency syndrome (AIDS)?
"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Name, address and telephone no. of personal physician _____

REMARKS—If you answered "YES" to any health question above, please provide details below.

Ques. No.	First Name	Description of illness, injury, or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects/ results	Name and address of attending physician or hospital (Include zip)

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. 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) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH 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.

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, Medical Information Bureau 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.

Employee's signature _____ Date _____

Spouse's signature (if spousal coverage) _____ Date _____

**NOTICE REGARDING MEDICAL INFORMATION BUREAU,
INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION**

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. 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.

In addition, we may obtain an investigative consumer report from an insurance support organization. If a report is prepared, upon request to your agent, you have the right to be personally interviewed in connection with the investigation. Also, upon proper request to Union Security Insurance Company, you may obtain a copy of the report.

Further, we or our reinsurers may obtain a report from and make a report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member for life or health coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply information contained in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of the information in its file. If the accuracy of the information is questioned, you may request that corrections be made by following the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's Information Office is PO Box 105, Essex Station, Boston, MA 02112, telephone 617.426.3660.

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. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

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, MO 64108-2670.