Employee Application
* Required Field

ASSURANT Employee Benefits

G. O. no. _____

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*	Married*	Children *	Earnings	Employee Soc. Sec. no.
☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Hourly No. hrs. per week ____ ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other ____	State of residence
Job title or position				

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: ☐ Life ☐ Accidental Death & Dismemberment ☐ Optional Additional Life Amt. _____

☐ Short Term Disability ☐ Long Term Disability Optional Amount: ☐ STD ☐ LTD Amt. _____

☐ Dental

Dependent: ☐ Life ☐ 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? ☐ Yes ☐ No

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.

Write in any coverages being refused and reason for refusal.

BENEFICIARIES *(Please read information below before completing.)*

Last name First MI	Relationship*	
		☐ Primary ☐ Secondary
		☐ Primary ☐ Secondary
		☐ Primary ☐ 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.

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

create barcode

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 _____ Date _____