

Administrative Services Only Dental Employee Application



ASSURANT Employee Benefits

1st application Adding dependent Effective date _____

ALL AREAS MUST BE COMPLETED OR FORM WILL BE RETURNED; PRINT LEGIBLY OR TYPE.

EMPLOYEE INFORMATION

Name of employer VICTOR TREATMENT CENTERS, INC.	Plan no. K1900450	Division no.
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Name of employee (<i>last, first, middle initial</i>)	Part-time employment date Mo Day Yr	Full-time employment date Mo Day Yr
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Home address of employee (*street, city, state, zip code*)

Job title	Hours worked per week for this firm	Employee date of birth Mo Day Yr	Social Security no.	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
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List all dependents to be covered.

Last	First	Middle initial	Date of birth Mo/Day/Yr	Relationship to Employee

COVERAGES ELECTED

WAIVER SECTION

I am applying for: <input type="checkbox"/> Employee Dental only <input type="checkbox"/> Employee and Spouse Dental <input type="checkbox"/> Employee and Child(ren) Dental <input type="checkbox"/> Family Dental	I am <i>not</i> applying for the following coverage for which I am eligible: <input type="checkbox"/> Employee Dental Reason _____ <input type="checkbox"/> Spouse Dental Reason _____ <input type="checkbox"/> Child(ren) Dental Reason _____
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PLEASE READ CAREFULLY: I wish to apply for coverage under the dental plan administered by Union Security Insurance Company. I authorize my employer to deduct **premiums** from my earnings.

AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, insurance company, consumer reporting agency, employer, or any other organization to give Union Security Insurance Company or its reinsurers, **ALL INFORMATION** on my behalf including findings on dental care as they apply to me or any of my dependents who are to be covered.

I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original. This authorization will be valid for two and one half years (in Minnesota, 26 months) 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.

Signature of employee _____ Date _____

FOR COMPANY USE ONLY

Effective date _____ Date received _____

Union Security Insurance Company
 Mail to: Assurant Employee Benefits PO Box 419423 Kansas City Missouri 64141-6423
 T 800.757.9796 F 816.474.2422