

Extended Employee Application



ASSURANT Employee Benefits

(Please complete the health questions on page 2 of this application.)

G. O. no. _____

Group policy/participant no. 4015743		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		Employee home address and phone 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 _____					

Please mark X in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: Basic Life _____ Optional Additional Life _____ Amount in force _____
 Accidental Death & Dismemberment _____
 Short Term Disability Optional Additional STD _____ Amount in force _____
 Long Term Disability Optional Additional LTD _____ Amount in force _____
 Dental

Dependent: Please mark X in box before the dependents to be covered: Spouse Children
 Dependent Life _____ Amount in force _____
 Optional Additional Dependent Life _____ Amount in force _____
 Dependent Dental

Note—Coverages not specifically elected will not be made effective, even if not refused.
 ELECTIONS NOT VALID WITHOUT SIGNATURE.

Were you covered under another dental plan within the last 31 days? Yes No
 If "Yes," termination date _____ Reason for termination of other coverage _____

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
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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.

Union Security Insurance Company

Mail to: Assurant Employee Benefits PO Box 2939 Clinton Iowa 52733-2939
 Form 12 (12/98) (CA)

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 _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Used any illegal drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or your dependents pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or your dependents used tobacco, in any form in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your dependents ever had, been medically diagnosed, treated or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years?
"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure. | <input type="checkbox"/> | <input type="checkbox"/> |

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. 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) 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. 8) Understand that I have the right to select any dental care provider of my choice. 9) 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.

For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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 valid as the original. This authorization will be valid for two and one-half years from the date shown below. For claims purposes, this authorization will remain valid for the term of coverage of the policy if health insurance or the duration of the claim for non-health insurance. 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.