Employee Application

Please print clearly in blue or black ink.

ISSUE

Check one – Employer Use

| New Employee | 🗌 Change | COBRA 🗌 |
|--------------|----------|---------|
|--------------|----------|---------|

Employee Information – Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

| Emp | loyee name (<i>last, first</i> , | , initial) | Employer | | | Employment loca | ation | |
|---------|--|-------------|----------------|---------------------|------------|------------------------|-------------|---------------------------------|
| | | | | | | | | |
| Grou | p policy/participant # | Account | # or Bill Grou | ip Name | Cert. # | Employee SSN | Employe | e birthdate |
| Sex | Job title or position | Employe | e hire date | # hours per week | Farning | gs \$ | Married | Children |
| | | Employe | | | | - | | |
| ШМ | | | | | | urly 🗆 Weekly | | □ Yes |
| □F | | | | | ☐ Moi | nthly | □ No | □ No |
| Addr | ess | | City | 9 | tate | | Zip | |
| | ELECTIONS A | RE NOT | | OUT A SIGNATU | RE AT TH | IE END OF THIS AI | PPLICATION. | |
| | | | | | | | | |
| | ndent Information – | | d if Depende | | es | Ormalan | Dala | " |
| Name | e (Last name, First Na | me) | | Date of Birth | | Gender | Rela | tionship |
| | | | 1 | | | | | |
| | | | I | | | I | Ι | I |
| | | | | | | | | |
| | | | | | | | | |
| NOTE | = – Coverage not elec | ted will be | e assumed re | fused even if not s | pecificall | v refused | | |
| | | | | | | | | |
| Bene | | | | | | | | |
| Your | nay select the benefits | s below. | | | | | | |
| пе | mployee Life | | Voluntary Li | fe Amount Ele | ctina | | | |
| | 1 -) | | • | | - | he last 12 months? | _ □ Yes | □ No |
| 🗆 E | mployee AD&D | | • | D&D Amount Ele | | | _ | — |
| | ependent Life | | Voluntary Sp | pouse Amount Ele | cting | | | |
| | | | Name of Sp | ouse | | | | |
| | | | Date of birth | l | | | | |
| | | | Has your spo | | any form i | in the last 12 months? | ' 🗌 Yes | 🗌 No |
| | | | Voluntary Cl | | _ | \$5,000 | 10,000 | |
| _ | hort Term Disability | | Voluntary S | | · _ | | | |
| _ | ong Term Disability | | Voluntary L1 | TD Amount Ele | cting | | | |
| | ental – Employee | | | | | | | |
| Mail to | Security Insurance Compar : P.O. Box 981624 El Paso, :1(03/2010) | | 1624 | | | | к | Page 1 C4704 (7/2016) |

| Dental – Employee - Dental – Employee - | • | | | |
|--|-----------------------------------|---------------------------------|------------|----------------------|
| Dental – Employee - | | | | |
| — | ed under another dental plan wit | thin the last 31 days? | □ Yes | □ No |
| If "Yes," termina | · · · · · | son for termination of coverage | | |
| ☐ Vision – Employee | | | | |
| | Spouse | | | |
| | - | | | |
| Vision – Employee + | . , | | | |
| Critical Illness: | • | 2 (includes cancer option) | | |
| | Employee Critical Illness | · · · · | | |
| | Have you used tobacco in an | • | <u>,</u> , | □ Yes □ No |
| | □ Spouse Critical Illness | | 5: | |
| | Has your spouse used tobac | · | montho? | |
| | | | monuns : | 🗌 Yes 🔲 No |
| | Child(ren) Critical Illness | | | |
| Cancer: | | | | |
| | | ee + Spouse | • | , _ , |
| | Have you used tobacco, in ar | iy form in the past 12 months | 5 ! | 🗌 Yes 📋 No |
| Accident | Employee | Off the lab Dischilling Denset | 40 | |
| | | e Off the Job Disability Benefi | τ? | 🗌 Yes 🔲 No |
| | □ Child(ren) | | | |
| Beneficiaries - Applies | to all coverages for which a bene | eficiary designation is require | d | |
| Last Name First | MI | Relationship | | |
| | | | 1 | |
| | | | | Primary |
| | | | L : | Secondary |
| | | | | Drimon |
| | | | | Primary Secondary |
| | | | | coolinaary |

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) Beneficiaries elected will apply to all coverage elected on this form for which a beneficiary designation is required.
- 3) If primary/secondary election is not noted, the beneficiary will be considered primary.
- 4) 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.
- 5) If your designation does not fit in the above arrangement, or you want to specify a beneficiary by coverage, please contact Union Security Insurance Company for the appropriate forms.

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 any 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 the 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) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

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 |
|-----------------------|-----------------------|------|
| AGENT, BROKER, AND/OR | ENROLLER INFORMATION: | |
| Agency Name: | | - |
| Agent/Broker Name: | | - |
| Enroller Name: | | - |
| | | |