Employee Application

Please print clearly in blue or black ink.

RENEWAL

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.*

Employee name *(last, first, initial)*	Employer	Employment location

Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate

Sex	Job title or position	Employee hire date	# hours per week	Earnings $_____	Married	Children
☐ M ☐ F				☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other_____	☐ Yes ☐ No	☐ Yes ☐ No

Address	City	State	Zip

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

Dependent Information — *Required if Dependent coverage applies*

Name (Last Name, First Name)	Date of Birth	Gender	Relationship

NOTE — *Coverage not elected will be assumed refused even if not specifically refused*

Employee Choice Life, Critical Illness Benefits

You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Accept	Refuse	Coverage
☐	☐	Employee Voluntary Life - Amount _____
☐	☐	Employee Matching Voluntary AD&D
☐	☐	Spouse Voluntary Life - Amount _____
☐	☐	Spouse Matching Voluntary AD&D
☐	☐	Child(ren) Voluntary Life - Amount _____
☐	☐	Child Matching Voluntary AD&D
☐	☐	Critical Illness

☐ Employee Critical Illness - Amount _____
Have you used tobacco, in any form in the past 12 months? ☐ Yes ☐ No

☐ Spouse Critical Illness - Amount _____
Has your spouse used tobacco, in any form in the past 12 months? ☐ Yes ☐ No

☐ Child(ren) Critical Illness - Amount _____

Beneficiaries - *Applies to all coverages for which a beneficiary designation is required*

Last Name	First	MI	Relationship	
				☐ 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) Beneficiaries elected will apply to all coverages 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.
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 coverages include limitations and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits. 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.

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____

Employee Health Statement

Please print clearly in blue or black ink.

VOLUNTARY AND WORKSITE COVERAGE

Check one — Employer Use

☐ New Enrollee ☐ Annual Enrollment ☐ Life Event-Type/Date

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.*

Employee name *(last, first, initial)*	Employer			
Group policy/participant #	Account #	Cert. #	Employee SSN	Employee birthdate

Answer the following questions based upon the coverage for which you are applying for you and your dependents - *For CRITICAL ILLNESS and LIFE, answer questions 1 through 6.*

Applicant Height:_____ Weight: _____ Spouse Height: _____Weight:_____

		YES	NO
1.	Have you or your dependents used tobacco in any form in the past 12 months?	☐	☐
2.	In the last 10 years, have you or your dependents been diagnosed, treated, or received advice to seek treatment for any tumor, malignancy or any type of internal cancer, melanoma, leukemia, lymphoma, sarcoma or Hodgkin's disease or been diagnosed with an elevated PSA, abnormal Pap or colposcopy? Have you had a hysterectomy or prostate removal?	☐	☐
3.	In the past 5 years, have you or your dependents been hospitalized, undergone any inpatient or outpatient surgery or procedure or been advised to be hospitalized or have surgery by a physician or medical provider?	☐	☐
4.	In the past 12 months, have you or your dependents been prescribed or advised to take prescription medication?	☐	☐
5.	Have you or your dependents ever been diagnosed, received treatment, or been advised to seek treatment for any mental, psychiatric, emotional or eating disorder, alcoholism, alcohol abuse, prescription or illegal drug abuse? Have you or your dependents ever been arrested for DUI, illegal drug possesion or use?	☐	☐
6.	Have you or your dependents ever been diagnosed, received treatment, or been advised to seek treatment for: **(circle all that apply and provide details below)**	☐	☐
	diabetes, heart or vascular disease, heart attack, blood disorder, stroke, high blood pressure, asthma, emphysema or other lung disorder, kidney disease, liver disease, gallstones, pancreas disorder, colitis, Crohn's disease, glaucoma, seizures, lupus or autoimmune disorder, multiple sclerosis, Parkinson's, Muscular Dystrophy or any paralysis, arthritis, disorder of the back, neck, spine, or joint, including hip or knee?		
	Have you or your dependents ever been diagnosed, treated, or advised to seek treatment for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)?	☐	☐
7.	Have you or your dependents ever been diagnosed with or treated for fibromyalgia, chronic fatigue, chronic pain, carpal tunnel, muscle or nerve disorder, eye or ear disorder, vertigo, bowel or bladder disorder?	☐	☐

NOTE — ***"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state or structure.***

Remarks — *If you answered "Yes" to any medical questions above, please provide details below:* ***Sign and date the form on back.***

Question No.	First Name	Description of illness, injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual Effects	Name and address of attending physician or hospital (including zip)

Employee name *(last, first, initial)*	Employer

Group policy/participant #	Account #	Cert. #	Employee SSN	Employee birthdate

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

AUTHORIZATION TO RELEASE INFORMATION: To properly underwrite applications, determine eligibility for coverage and issue insurance policies on an equitable basis, we must obtain information about you. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics and information. 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.

By signing below, I authorize any provider of medical services, physicians, or other medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager or any pharmacy related services entity, insurance company, employer, consumer reporting agency, or other individual or entity to give Union Security Insurance Company or its reinsurers any information regarding my medical or health history. Such information includes but is not limited to any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or pharmacy records.

I understand that I have the right to refuse to sign this authorization but if I refuse, Union Security Insurance Company may refuse to consider my application for enrollment. I understand that a photocopy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is voluntary and that I may revoke it at any time by writing Union Security Insurance Company, P.O. Box 419052, Kansas City, MO 64141-6052, Attn: Privacy Office. Such revocation will not affect any action taken by Union Security Insurance Company prior to receipt of the revocation. If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.

The authorization is effective from the date signed below until the earliest of denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Union Security Insurance Company, but at no time longer than 30 months.

Federal law requires that we inform you that the information which we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. However, be assured that disclosure will be strictly limited to that which is reasonably necessary and we will comply with all federal and state privacy and security laws and regulations. You have the right to gain access to and request correction of information contained in our files.

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) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
5) Understand that coverages include limitations and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

This will certify that I HAVE read and understand the above important notice.

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_____

Spouse's signature (if spouse coverage elected) _____ Date_____