Employee Health Statement

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

Group policy/participant no.	Account no.	Cert. no.	Employee SSN	Employee birthdate

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

Please answer the following questions. 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 in the past 12 months? If yes, how much _____	☐	☐
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? b) Used any illegal drug?	☐	☐
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?	☐	☐
4. Are you or your dependents pregnant?	☐	☐
5. Have you or your dependents used tobacco, in any form in the past 12 months?	☐	☐
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 or immune system disorder? "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure	☐	☐

Name, address and telephone number of personal physician _____

Employee's address _____ Daytime phone ( ) _____

If you answered "YES" to any questions, please provide details in REMARKS below.
And be sure to SIGN your form on the REVERSE side.

REMARKS

If you answered "Yes" to any medical questions above, please provide details below:

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)

Union Security Insurance Company
Mail to: P.O. Box 981624, El Paso, TX 79998-1624
T 800.733.7879 F 888.208.2323

Employee name		Employer
Group policy/participant no.	Account no.	Cert. no.

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, insurance company, consumer reporting agency, employer, Medical Information Bureau, consumer reporting agency, insurance, 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 contacting 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 the short term disability plan/long term disability plan includes limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

This will certify that <u>I HAVE</u> 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 _____