Union Security Life Insurance of New York

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 to the best of your knowledge and belief. 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 (except HIV), 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 been treated for or diagnosed as having: 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 (except HIV)? "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" toany 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: (Use separate sheet if necessary)

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

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

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 and information. This information will be collected from you and various sources, including health professionals and health facilities. nformation regarding factors affecting insurability will be treated as confidential.

We may obtain an investigative consumer report, based on interviews with neighbors, acquaintances, and business contacts, concerning the character, general reputation, personal characteristics, and mode of living of any individuals involved in this application. Upon written request, the Company will: furnish detailed information as to the nature and scope of any such investigations, inform you if it was requested, and if it was, also furnish you with the name and address of the reporting agency to whom the request was made. You may inspect and receive a copy of such report by contacting the reporting agency.

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.

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, Missouri 64108

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

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 or any other organization to give UNION SECURITY LIFE INSURANCE COMPANY OF NEW YORK or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information (except as protected by Federal regulations), 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 LIFE INSURANCE COMPANY OF NEW YORK 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 as valid as the original. This authorization will be valid for two years from the date shown below. I know that I have the right to revoke this authorization at any time. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

Employee name		Employer

Group policy/participant no.	Account no.	Cert. no.

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 Life Insurance Company of New York. (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 Life Insurance Company of New York. (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. (6) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU. (7) I have read and agree with the Authorization to Release Information.

Pursuant to Section 403(d) and Regulation 95 of the New York State Insurance Law, the following statement applies to our accident and health policies only: "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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation."

Employee's signature ______________________________ Date ______________

Spouse's signature (if spouse coverage elected) ______________________ Date ______________