Employee Application for Conversion Coverage
Long Term Disability Insurance

To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the pages.

FRAUD STATEMENTS

Please read the following before completing the attached form.

If you live in the states of Arkansas, Louisiana or Rhode Island, the following statement applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of California, the following statement applies to you: 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.

If you live in the state of Colorado, the following statement applies to you: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you live in the District of Columbia, the following statement applies to you: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

If you live in the state of Florida, the following statement applies to you: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

If you live in the state of Maryland, the following statement applies to you: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of New Hampshire, the following statement applies to you: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

If you live in the state of New Jersey, the following statement applies to you: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

If you live in the state of Oregon, the following statement applies to you: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

If you live in the state of Virginia, the following statement applies to you: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

If you live in a state other than mentioned above, the following statement applies to you: 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.

Union Security Insurance Company
Mail to: PO Box 219304 Kansas City Missouri 64121
T 866.909.6065

Employee Application For Conversion Coverage
Long Term Disability Insurance

1. Prospective person insured _____ Date of birth _____

2. Address _____
NUMBER AND STREET

_____
CITY STATE ZIP CODE

3. Group policyholder _____

4.Group policy no. _____ 5. Certificate no. _____ 6. Social Security no. _____

7.Effective date of group insurance _____ 8. Termination date of group insurance _____

9. Reason for termination _____

10. Is there now in effect, or applied for but not yet issued, any other coverage (group or otherwise) providing Long Term Disability Benefits? ☐Yes ☐No If "Yes," please furnish details of this coverage or a copy of the benefit booklet.

_____

_____

11. Initial quarterly premium _____ **Note**: All checks must be drawn to the order of Union Security Insurance Company. If accepted, are accepted subject to collection.

I HEREBY: A) Request application under a Group Long Term Disability Insurance Conversion Policy to become effective on the day following the date of termination shown in item 8 above, B) declare that the coverage for which application is requested is to replace the Long Term Disability Insurance under the group policy identified in item 4 above, C) agree that the coverage for which application is requested shall not become effective unless application is approved by Union Security Insurance Company according to its underwriting rules and procedures for conversion coverage currently in effect, and D) certify that all of the above statements are, to the best of my knowledge and belief, true and complete.

Signed at _____ Date _____
CITY AND STATE OR OTHER JURISDICTION

Signature _____ Signature _____
WITNESS PROSPECTIVE INSURED

(over)

POLICYHOLDER VERIFICATION *(To be completed and signed by the Group Policyholder)*

1. Name of group policyholder _____ Group policy no. _____

2. Name of employee _____ Cert. no. _____

3. Effective date of applicant's insurance under the group policy _____

4. A. Date applicant's insurance terminated _____

   B. Reason for termination _____

   C. Had the applicant been insured under the Group Long Term Disability Policy for at least 12 consecutive months on the date of termination? (If not solely with Union Security Insurance Company, then under a prior Group Long Term Disability plan, if any, which the Union Security Insurance Company plan replaced?) ☐Yes ☐No

   D. Applicant's insured monthly salary on the date of termination $_____

5. Date notice of conversion privilege given to employee _____

6. Is the employee filing a claim for, or currently receiving Group Long Term Disability Benefit? ☐Yes ☐No

Signature _____ Date _____
AUTHORIZED POLICYHOLDER REPRESENTATIVE

FOR HOME OFFICE USE ONLY

I.D. no. _____

Cert. no. _____

Date cert. mailed _____

Effective date _____

First premium paid in full _____

Last premium paid _____

Claim paypoint _____

LTD gross benefit _____