Employee Application

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

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.*

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*

Benefits
You may select the benefits below.

☐ Employee Life
☐ Voluntary Life Amount Electing _____
Have you used tobacco in any form in the last 12 months? ☐ Yes ☐ No

☐ Employee AD&D
☐ Voluntary AD&D Amount Electing _____

☐ Dependent Life
☐ Voluntary Spouse Amount Electing _____
Name of Spouse _____
Date of birth _____
Has your spouse used tobacco in any form in the last 12 months? ☐ Yes ☐ No

☐ Voluntary Child ☐ $1,000 ☐ $5,000 ☐ $10,000

☐ Short Term Disability ☐ Voluntary STD Amount Electing _____

☐ Long Term Disability ☐ Voluntary LTD Amount Electing _____

☐ Dental – Employee

☐ Dental – Employee + Spouse

☐ Dental – Employee + Child(ren)

☐ Dental – Employee + Family

Were you covered under another dental plan within the last 31 days? ☐ Yes ☐ No

If "Yes," termination date _____ Reason for termination of coverage _____

☐ Vision – Employee

☐ Vision – Employee + Spouse

☐ Vision – Employee + Child(ren)

☐ Vision – Employee + Family

☐ Critical Illness: ☐ Level 1 ☐ Level 2 (includes cancer option)

☐ Employee Critical Illness Amount Electing _____

Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No

☐ Spouse Critical Illness Amount Electing _____

Has your spouse used tobacco in any form in the past 12 months? ☐ Yes ☐ No

☐ Child(ren) Critical Illness Amount Electing _____

☐ Cancer: ☐ Level 1 ☐ Level 2

☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Have you used tobacco, in any form in the past 12 months? ☐ Yes ☐ No

☐ Accident ☐ Employee

☐ Spouse - Include Spouse Off the Job Disability Benefit? ☐ Yes ☐ No

☐ Child(ren)

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 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.

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.

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____