Group Insurance Preliminary Application

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 Kansas, 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 as determined by a court of law.

If you live in the state of Kentucky, 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 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.

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 North Carolina, the following statement applies to you:
It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid. Pursuant to NCGS 58-2-161(b), any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person 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.

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

Group Insurance Preliminary Application

Policy no. _____

UNDERWRITING COMPANY: UNION SECURITY INSURANCE COMPANY (THE INSURER)
(WE, US OR OUR WHEN USED HEREIN REFER TO THE INSURER.)

APPLICANT INFORMATION *(You and your when used herein refer to Applicant.)*

1. Exact legal name *(as it will appear in the contract and/or certificate).* Employer Tax ID no.

_____ _____

2. Full address and contact numbers of main office. **Note: Street address is required.**

Street Address _____

City _____ County _____ State _____ ZIP _____

P.O. Box _____ **Note: This address will be used for all correspondence.**

City _____ County _____ State _____ ZIP _____

Telephone no. _____ Fax no. _____ Website _____

Note: The contract will be issued in the state where the main office is located unless otherwise requested and approved.

3. Administrative Contact/Correspondent name:

☐ Mr. ☐ Mrs. ☐ Ms. _____ E-mail _____

Job Title _____

Is Administrative Contact/Correspondent an employee of the applicant? ☐ Yes ☐ No

If "No," form KC2064A Appointment of Administrator and Hold Harmless Agreement must be completed, including full address, and submitted with this preliminary application.

Bills will be sent to:
☐ Same as above
☐ Other *(Please give name, title and full address of recipient.)* _____

Renewal letters, with copy to broker, will be sent to:
☐ Same as above
☐ Other *(Please give name, title and full address of recipient.)* _____

You may elect to receive communications, policies, and forms related to products provided by us by e-mail transmission as available and allowed by relevant law and regulations*. Please indicate your consent to receiving these documents via e-mail, by checking the box next to "I Consent" below. If different from the e-mail address noted above, please provide an e-mail address for transmission of these documents.

☐ I consent to receive all communications, policies, and forms from Insurer by e-mail transmission.

E-mail address _____

*Please note that Certificates provided in electronic format must comply with the requirements described more fully in the Certificate and Contract Information section below.

COVERAGES APPLIED FOR

4. Employer Paid Plans: ☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vision
Voluntary Plans: ☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vision
☐ Accident Only ☐ Cancer Only ☐ Critical Illness ☐ Hospital Indemnity

Requested effective date(s) of insurance _____

_____

Requested Policy Anniversary *(if different)* _____

APPLICANT BUSINESS INFORMATION

5. Nature of business *(Give written details of actual products, services, manufacturing process and materials used, etc.)*

Years in business _____ SIC code _____

6. Business is organized as: ***(If owners of entities * below are covered, please identify on census or attach list.)***

☐ Corporation ☐ Partnership* ☐ Proprietorship*
☐ Government Funded Non-Profit ☐ Other Non-Profit ☐ Trust
☐ Sub-Chapter S Corp* ☐ Professional Corporation* ☐ Professional Association*
☐ Limited Partnership (LP)* ☐ Limited Liability Company (LLC)* ☐ Limited Liability Partnership (LLP)*
☐ Prof. Limited Liability Co. (PLCC)* ☐ Limited Liability Limited Partnership (LLLP)* ☐ Political Subdivision
☐ Federal Agency Executive Branch: ☐ Yes ☐ No If "Yes," subject to Executive Order 11246? ☐ Yes ☐ No
☐ Church Group If this is checked, it is: ☐ ERISA ☐ Non-ERISA
☐ School Group If this is checked, it is: ☐ Public ☐ Private
☐ Other *(Specify.)* _____

7. Financial Status *(If you answer "Yes," to any part, please provide explanation below.)*

☐ Yes ☐ No Has Applicant ever filed or does it anticipate filing for bankruptcy or similar insolvency?
☐ Yes ☐ No Does Applicant anticipate ceasing, materially reducing or altering active business operations?
☐ Yes ☐ No Has Applicant opted out or does it anticipate opting out of Worker's Compensation, Social Security or PERS *(if applicable)*?

Explanation _____

AFFILIATE OR SUBSIDIARY INFORMATION

8. **Indicate any affiliates or subsidiaries to be covered. An affiliate or subsidiary is a separate firm owned or controlled by the Applicant. Its employees will be insured under the policy only if requested below and approved by the Insurer. Please complete all the requested information for each affiliate or subsidiary to be covered under the policy. See question 6 for business type.**

Exact legal name _____ Employer Tax ID no. _____

Full address and contact numbers of main office. **Note: If a PO Box is used, a street address must also be included.**

Address _____

City _____ County _____ State _____ ZIP _____

Telephone no. _____ Fax no. _____ E-mail address _____

Contact name and title:

☐ Mr. ☐ Mrs. ☐ Ms. _____ Title _____

Nature of Business

Business Type	**SIC Code**	**No. of Employees**	**Percentage owned by Applicant**

If you have additional affiliates please provide them in an attached list.

COVERAGES

9. **Life and Accidental Death & Dismemberment Insurance**

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees/ Dependents
☐ Employer Paid Life		
☐ Accidental Death & Dismemberment		
☐ Dependent Life		
☐ Additional Contributory Life		
☐ Voluntary Life		
☐ Voluntary AD&D		
☐ Voluntary Dependent Life		

Is a similar insurance program currently available to your employees? ☐ Yes ☐ No

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently applying for a similar insurance program? ☐ Yes ☐ No If “Yes,” please explain. _____

Short and Long Term Disability Insurance

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees
☐ Employer Paid Short Term Disability		
☐ Employer Paid Long Term Disability		
☐ Voluntary Short Term Disability		
☐ Voluntary Long Term Disability		

Are any of your employees eligible for a State Disability Plan? ☐ Yes ☐ No If "Yes," which state(s)_____

Do you provide salary continuance or any kind of income replacement plan *(formal or informal)* other than the coverages requested above? ☐ Yes ☐ No If "Yes," which of the following best describe the plan? Check all that apply:

☐ Salary Continuance ☐ Short Term Disability ☐ Long Term Disability ☐ Other *(Please describe.)*_____

Do you or can your employees elect to include the cost of disability coverage in taxable income ("gross up")? ☐ Yes ☐ No

Is a similar insurance program currently available to your employees? ☐ Yes ☐ No

Will the plan(s) requested replace other coverages as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently applying for a similar insurance program? ☐ Yes ☐ No If "Yes," please explain. _____

Dental Insurance

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees/ Dependents
☐ Employer Paid Employee Dental		
☐ Dependent Dental		
☐ Voluntary Employee Dental		
☐ Dependent Dental		

Is a similar insurance program currently available to your employees? ☐ Yes ☐ No

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently applying for a similar insurance program? ☐ Yes ☐ No If “Yes,” please explain. _____

Are you also selecting a DHMO dental plan? ☐ Yes ☐ No

If “Yes,” please provide a completed Group Dental Services Agreement.

Vision Insurance

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees/ Dependents
☐ Employer Paid Employee Vision		
☐ Dependent Vision		
☐ Voluntary Employee Vision		
☐ Dependent Vision		

Is a similar insurance program currently available to your employees? ☐ Yes ☐ No

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently applying for a similar insurance program? ☐ Yes ☐ No If "Yes," please explain. _____

Supplemental Voluntary Insurance

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees
☐ Accident Only		
☐ Cancer Only		
☐ Critical Illness		
☐ Hospital Indemnity		

Is a similar insurance program currently available to your employees? ☐ Yes ☐ No

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? ☐ Yes ☐ No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently applying for a similar insurance program? ☐ Yes ☐ No If "Yes," please explain. _____

Other* (Must also purchase a fully insured product.)

☐ Employee Assistance Program

☐ Healthy Solutions Discount Card. If elected, please complete the Healthy Solutions Group Information form.

☐ Vision Services Plan (Vision Discount Program) Not available if Vision Insurance is elected.

***Products and Services provided by third-party vendors under separate agreements with Applicant. Not available on all coverages.

SECTION 125 PLAN

10. Do you have a Section 125 Plan? ☐ Yes ☐ No **If "No," please proceed to question 11.**

Will any portion of the requested coverages be paid with post-tax premium as part of the Section 125 Plan? ☐ Yes ☐ No

If "Yes," please indicate which coverages: _____

(Note: If Will Preparation Services, Disability and Elder Care Planning, Financial Counseling or Healthy Solutions are included with the above listed coverages, they are not considered qualified benefits under IRC § 125 and will be excluded from the contract(s).)

Annual Enrollment Period for Section 125 Plan: From _____/_____ *(m/d)* To _____/_____ *(m/d).*
Please note, Life Events/Change in Family Status will be defined per our standard language unless a copy of your 125 Plan is submitted for review and approval.

Plan included? ☐ Yes ☐ No

BILLING

11. Who will bill the coverages requested?

☐ The Insurer *(with online administration included at no cost)*

☐ Policyholder *(Self-Administration with approval of the Insurer)*

Note: For Self-Administration you must agree to provide a complete census to the Insurer upon request and at least once a year.

Do you want the Insurer to prepare the initial bill? ☐ Yes ☐ No

☐ Third Party Administrator **Note: TPA must be approved by the Insurer prior to submitting case and Applicant must complete and submit form KC0262 Administrator Application.**

12. Premium is to be billed: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

For Voluntary coverages:

Complete the following section if your policy includes at least one Voluntary coverage.

Payroll cycle is: ☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Semi-Monthly (24) ☐ Monthly (12) ☐ Other _____

Deductions will be made: ☐ In advance of the coverage period ☐ During the coverage period

The first deduction period will start on _____/_____ *(m/d)* and will end on _____/_____ *(m/d).*

Voluntary premium will be paid: ☐ In advance of the coverage period ☐ At the end of the coverage period.

13. How would you like your bill structured?

☐ Single bill with all employees and coverages

☐ Single bill with employees grouped by*: ☐ Location ☐ Division/Department ☐ Other, defined below

☐ Multiple bills split by*: ☐ Location ☐ Division ☐ Employer Paid/Voluntary ☐ Other, defined below

***** Please provide detail.

_____

_____

If more space is needed, please provide an attached list and indicate here that an attachment exists: ☐ Attachment

14. How would you like to receive your bill?

With your plan you will receive access to Online Advantage where you can review your bill and make changes online. You will receive e-mail notification when bills are available for review online.

☐ Online *(Default)*

☐ Online and paper bills

☐ Paper bills

ADMINISTRATION

15. Annual Enrollment Period for coverages not included in Section 125 Plan: From _____/_____ *(m/d)* To _____/_____ *(m/d).*
(Default is the calendar month 2 months prior to Policy Anniversary.)

16. Service Requirement – the amount of time required before employees are eligible for benefits. Applies to **all** coverages unless otherwise stated.

A. Current employees hired on or before the effective date are eligible for benefits: *(Choose one of the following if selecting days or months. Please write in the number of days or months.)*

☐ Immediately ☐ Days ☐ Months

_____

B. Future employees hired after the effective date are eligible for benefits: *(Choose one of the following if selecting days or months. Please write in the number of days or months.)*

☐ Immediately ☐ Days ☐ Months

_____

17. Entry date – when an enrolled employee becomes insured.

A. For **Employer paid** coverages: ☐ Immediate ☐ 1st of the month occurring on or after
☐ Other *(Specify.)* _____

B. For **Voluntary** coverages: ☐ 1st of the month occurring on or after
☐ Other *(Specify.)* _____

18. Earnings definition: ☐ Standard
☐ Other *(requires Home Office approval.)* Please specify request.

_____

19. Full-time definition: ☐ Standard (30 hours for Employer paid, 20 hours for Voluntary coverages)
☐ Other (*requires Home Office approval.)* Please specify request.

_____

20. A. Effective date for changes for **Employer paid** coverages

Due to salary changes: ☐ Immediate ☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____

Due to age: ☐ Immediate ☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____

B. Effective date for changes for **Voluntary** coverages

Due to salary changes: ☐ Policy Anniversary ☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____

Due to age: ☐ Policy Anniversary ☐ 1st of month occurring on or after ☐ Other *(Specify.)* _____

C. Termination date for **Dental** Coverage: ☐ End of the month in which employment terminates ☐ Immediate
(Termination date for all other coverages is immediate.)

BENEFICIARY INFORMATION

21. For Life Insurance or Accident Only Insurance, will you maintain beneficiary information? ☐ Yes ☐ No

If "Yes," you must agree to maintain all records pertaining to the beneficiary of Life Insurance or Accident Only Insurance and all subsequent beneficiary changes. Note: All assignments or irrevocable designations must be submitted to the Insurer for review and approval, accompanied by the original enrollment form.

If "No," you must agree to submit the original enrollment form and all subsequent beneficiary changes to the Insurer.

CERTIFICATE AND CONTRACT INFORMATION

22. **Certificates are provided in electronic format for all coverages.** Please review the following statement regarding your responsibilities in relation to electronic certificates.

SIGNIFICANCE: Electronic Certificates ("e-certs") provide important information about insurance coverage and protection for insureds under the policy. You must agree that you will: (1) Distribute e-certs to insureds under the policy; (2) not release or otherwise transfer e-certs to third parties (other than insureds), without the Insurer's prior written approval; (3) not alter, modify or otherwise change e-certs and will ensure that adequate security is in place to prevent insureds from doing the same; (4) take measures to ensure that the system furnishing e-certs results in actual receipt of the information by each insured (use return-receipt electronic mail features or periodic review/surveys to confirm receipt) and (5) convey to each insured the **significance** of e-certs, that the certificate is being furnished electronically and that the insured may request and receive a paper copy at no charge.

☐ **Yes, I am able to comply with e-cert responsibilities and would like certificates provided in electronic format.**

☐ **No, I am unable to comply with e-cert responsibilities and would like paper certificates.**

23. Summary Plan Description (SPD): ERISA Plan Information. ERISA requires employers to distribute SPD's for most employer-sponsored benefit plans. To the best of our knowledge, the certificate can serve as your SPD if certain plan information and a statement of ERISA rights are provided with the certificate.

Should we include ERISA information for an SPD? ☐ Yes ☐ No If "Yes," supply the following information.

Name of the plan _____

If other than the policyholder, please provide the full name, address and phone number of the:

Plan sponsor _____

Plan administrator _____

Agent for service of legal process _____

Plan number(s) _____ **Note:** The plan number is PN501 unless another number is assigned by the employer or the Plan Administrator.

EMPLOYEE INFORMATION AND VERIFICATION

24. Employees at active work:

☐ Applicant certifies that all employees are at active work at their usual place of business on date this Preliminary Application is signed.

☐ There are employees who are not at active work at their usual place of business on date this Preliminary Application is signed. They are listed below.

Name	Date of Birth	Insurance Amount	Nature of Illness or Reason for Absence

25. Are any employees located outside the United States? ☐ Yes ☐ No If “Yes,” please provide the name of the employee(s), location and country of citizenship. Advise how long the employee will be located outside the United States.

_____

_____

_____

Please note, employees working outside the United States are not covered by the policy unless agreed to, in writing, by the Insurer.

26. If this Preliminary Application is being signed after the requested effective date, you must complete the following:

☐ Applicant certifies that there have been no claims incurred since the requested effective date and Applicant is unaware of any changes in medical condition or status.

APPLICANT AGREEMENT

1. By signing and agreeing to this Preliminary Application on behalf of the Applicant, the undersigned:
   A. Certifies that he/she is authorized to sign this Preliminary Application on behalf of the Applicant;
   B. Certifies that the information contained herein is true and correct to the best of the Applicant's knowledge and belief and understands that it forms the basis for its request for insurance. Omission or misstatement of known information on this Preliminary Application could affect the validity of any insurance issued and cause denial of a claim;
   C. Understands that the requested insurance will:
      1. Be issued only if the requested insurance is acceptable to the Insurer and is legally permissible;
      2. Be issued under a group policy(ies) in the language customarily used by the Insurer;
      3. Be subject to the Insurer's usual underwriting requirements (including evidence of insurability, if applicable);
      4. Take effect on the date determined by the Insurer; and
      5. Not be effective until this Preliminary Application is approved and accepted by the Home Office of the Insurer in Kansas City MO;
   D. Understands that no agent or broker has the authority to accept or guarantee acceptance of the requested insurance;
   E. Understands that this Preliminary Application may be a request to participate in the Insurer's Small Group or Voluntary Trust Plans as determined by the Insurer's underwriting rules. If this item E applies and the Insurer approves and accepts this Preliminary Application, Applicant agrees to be bound by the terms of the group policy(ies) issued to the Trustees of the applicable Trust Plans;
   F. Agrees to offer the requested insurance to all eligible employees of the Applicant; and
   G. Agrees that the effective date of the requested insurance for which an employee is required to submit evidence of insurability will be determined in accordance with the group policy's terms and will be subject to the active work requirement and further agrees not to:
      1. Collect or pay premiums (other than any initial deposit) for such insurance before receiving the Insurer's approval notice; and
      2. Distribute material describing the policy coverage to such persons to be insured without the Insurer's prior written consent.
2. If premium is paid with the Preliminary Application, that amount will be applied toward the first premium due for coverages requested. This amount will be returned if the requested insurance does not become effective. Cashing of the check by the Insurer is not acceptance and approval of this Preliminary Application. $_____ has been paid with this Preliminary Application.
3. The requested coverage provides benefits for the employee welfare benefit plan established and maintained by the employer - Applicant under the Employee Retirement Income Security Act (ERISA), unless otherwise exempted by law.
4. If the requested insurance is approved and accepted, that insurance will automatically terminate if the premiums are not paid before the end of the grace period following the due date. Payment of premiums for coverage during the grace period is required. Insurance coverage will also terminate if the number or percentage of participants falls below that required by the group policy.
5. No one except the President, Senior Vice President or Chief Financial Officer of the Insurer may make, alter or discharge contracts or waive any of the Insurer's rights or requirements.

Applicant's Signature _____ Print name _____

Title _____ Date *(required)* _____

Insurer's representative _____ Date _____

PRODUCER INFORMATION

The following information must be fully completed and signed before processing can be completed.
Box Number 2 should only be completed if a Commission Split has been approved.

1. Please select to whom Commissions are to be paid.	**2. Please select to whom Commissions are to be paid:**
☐ Individual ☐ Firm ☐ Broker's Broker	☐ Individual ☐ Firm ☐ Broker's Broker
Individual or firm (legal name)	Individual or firm (legal name)
Tax ID no. _____ Commission Split _____	Tax ID no. _____ Commission Split _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
E-mail address _____	E-mail address _____
Phone no. _____ Fax no. _____	Phone no. _____ Fax no. _____
Payee no. _____ License no. _____	Payee no. _____ License no. _____
Writing Agent _____	Writing Agent _____
Signature _____ Date _____	Signature _____ Date _____

Note: Agent/Broker must note his/her license number for contract state.