

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:	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. _____ E-mail _____	
Job Title _____	
Is Administrative Contact/Correspondent an employee of the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
<input type="checkbox"/> Same as above	
<input type="checkbox"/> Other (Please give name, title and full address of recipient.) _____	
Renewal letters, with copy to broker, will be sent to:	
<input type="checkbox"/> Same as above	
<input type="checkbox"/> 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.	
<input type="checkbox"/> 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:	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Voluntary Plans:	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
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 Limited Liability Partnership (LLP)*
- Sub-Chapter S Corp* Professional Corporation* Political Subdivision
- Limited Partnership (LP)* Limited Liability Company (LLC)*
- Prof. Limited Liability Co. (PLCC)* Limited Liability Limited Partnership (LLLLP)*
- 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?

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

Dental Insurance

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees/ Dependents
<input type="checkbox"/> Employer Paid Employee Dental	_____	_____
<input type="checkbox"/> Dependent Dental	_____	_____
<input type="checkbox"/> Voluntary Employee Dental	_____	_____
<input type="checkbox"/> 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. _____

Vision Insurance

Check all that apply and complete required fields:	Employer Contribution %	No. of Eligible Employees/ Dependents
<input type="checkbox"/> Employer Paid Employee Vision	_____	_____
<input type="checkbox"/> Dependent Vision	_____	_____
<input type="checkbox"/> Voluntary Employee Vision	_____	_____
<input type="checkbox"/> 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. _____

SECTION 125 PLAN

9. 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

10. 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.**

11. 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.

12. 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

13. 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

14. 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.)

15. 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

16. 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.) _____

17. Earnings definition: Standard

Other (requires Home Office approval.) Please specify request.

18. Full-time definition: Standard (30 hours for Employer paid, 20 hours for Voluntary coverages)

Other (requires Home Office approval.) Please specify request.

19. Termination date for Dental Coverage:

End of the month in which employment terminates Immediate

(Termination date for all other coverages is immediate.)

CERTIFICATE AND CONTRACT INFORMATION

20. **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.**

21. 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

22. Employees at active work:

- Applicant indicates 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

23. 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.

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

- Applicant indicates 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, submitting and agreeing to this Preliminary Application on behalf of the Applicant, the undersigned:
 - A. Indicates that he/she is authorized to sign this Preliminary Application on behalf of the Applicant;
 - B. Indicates 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;
 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. Agrees to offer the requested insurance to all eligible employees of the Applicant; and
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.

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.

Applicant's Signature _____ Print name _____
 Title _____ Date (required) _____
 Insurer's representative _____ Date _____

The vision policy provides vision benefits only. Review your policy carefully.

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:
<input type="checkbox"/> Individual <input type="checkbox"/> Firm <input type="checkbox"/> Broker's Broker	<input type="checkbox"/> Individual <input type="checkbox"/> Firm <input type="checkbox"/> 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 _____
<i>Note: Agent/Broker must note his/her license number for contract state.</i>	