Employee Application

Please print clearly in blue or black ink.

ISSUE

ASSURANT Employee Benefits®

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

VISION BENEFITS— You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

☐ Employee Vision

☐ Dependent Vision – Child(ren)

☐ Dependent Vision – Spouse

☐ Dependent Vision – Family

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. (3) Authorize any required deductions from my earnings. (4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

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.

Employee's signature _____ Date _____

Union Security Insurance Company
Mail to: **Assurant Employee Benefits**: P.O. Box 2939 Clinton, IA 52733-2939