# Employee Application

*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.

<table>
<thead>
<tr>
<th>Employee name (last, first, initial)</th>
<th>Employer</th>
<th>Employment location</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Group policy/participant #</th>
<th>Account # or Bill Group Name</th>
<th>Cert. #</th>
<th>Employee SSN</th>
<th>Employee birthdate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Job title or position</th>
<th>Employee hire date</th>
<th># hours per week</th>
<th>Earnings $</th>
<th>Married</th>
<th>Children</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

**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 |
| --- | --- | --- | --- |

<table>
<thead>
<tr>
<th>Name of Spouse</th>
<th>Date of birth</th>
<th>Has your spouse used tobacco in any form in the last 12 months?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Voluntary Life</th>
<th>Amount Electing</th>
<th>Have you used tobacco in any form in the last 12 months?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Voluntary AD&amp;D</th>
<th>Amount Electing</th>
<th>Voluntary Spouse</th>
<th>Amount Electing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Spouse</th>
<th>Date of birth</th>
<th>Has your spouse used tobacco in any form in the last 12 months?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Voluntary Child</th>
<th>$1,000</th>
<th>$5,000</th>
<th>$10,000</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Voluntary STD</th>
<th>Amount Electing</th>
<th>Voluntary LTD</th>
<th>Amount Electing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Voluntary Child</th>
<th>$1,000</th>
<th>$5,000</th>
<th>$10,000</th>
</tr>
</thead>
</table>

**NOTE – Coverage not elected will be assumed refused even if not specifically refused**

## Benefits

You may select the benefits below.

- [ ] Employee Life
- [ ] Employee AD&D
- [ ] Dependent Life
- [ ] Short Term Disability
- [ ] Long Term Disability
- [ ] Dental – Employee

Union Security Insurance Company
Mail to: P.O. Box 981624 El Paso, TX 79998-1624
Form 61(03/2010)(OR)
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 ______________
□ Spouse Critical Illness Amount Electing ______________
□ Child(ren) Critical Illness Amount Electing ______________

Have you used tobacco in any form in the past 12 months? □ Yes □ No
Has your spouse used tobacco in any form in the past 12 months? □ Yes □ No

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.

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.

Employee’s signature   _______________________________ Date ______________________

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name:  ________________________________

Agent/Broker Name:  ________________________________

Enroller Name:  ________________________________