

Extended Employee Application



ASSURANT Employee Benefits

(Please complete the health questions on the reverse side of this application.)

G. O. no. _____

Group policy/participant no.	Account no.	Cert. no.	Employer	Employment location/phone no.		
Employee name (last, first, initial)		Part-time employ. date Month Day Year	Full-time employ. date Month Day Year	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee date of birth Month Day Year	Earnings _____ <input type="checkbox"/> Hourly No. hrs. per week _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____	Job title or position		State of residence	Employee Soc. Sec. no.	
Status: (If status area is not completed, we consider the employee to be active.) <input type="checkbox"/> Retired <input type="checkbox"/> Continuation <input type="checkbox"/> Leave of absence Reason _____ Date _____				Employee home address and phone no. ()		

Please mark X in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: Basic Life _____ Optional Additional Life _____ Amount in force _____
 Accidental Death & Dismemberment _____
 Short Term Disability Optional Additional STD _____ Amount in force _____
 Long Term Disability Optional Additional LTD _____ Amount in force _____
 Dental

Dependent: **Please mark X** in box before the dependents to be covered: Spouse Children
 Dependent Life _____ Amount in force _____
 Optional Additional Dependent Life _____ Amount in force _____
 Dependent Dental

Note—Coverages not specifically elected will not be made effective, even if not refused.
 ELECTIONS NOT VALID WITHOUT SIGNATURE.

Were you covered under another dental plan within the last 31 days? Yes No
 If "Yes," termination date _____ Reason for termination of other coverage _____

If spouse coverage is being applied for, complete the following.

Name of Spouse	Date of Birth Month Day Year	Social Security No.	Employer	Current Dental Insurance Carrier
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Write in the names and dates of birth of children to be covered (subject to plan provisions).

Write in any coverages that you/your dependents are refusing and the reason for refusal.

BENEFICIARIES

Last name	First	MI	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> 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) If primary/secondary election is not noted, the beneficiary will be considered primary. 3) 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. 4) If your designation does not fit in the above arrangement, please contact Union Security Life Insurance Company of New York for the appropriate forms.

Union Security Life Insurance Company of New York

Administrative Office: PO Box 2981 Clinton Iowa 52733-2981

Plan Type	Coverage Effective Date Mo. Day Yr.			Plan I.D.	Schedule Class	Reduct. Cat.	Rate Class	Evid. Acpt.	Rate Sct.	Benefit Volume	Trans. Cd.	Frz. Cd.
Evidence Type	# of lives	Serv. req.	Policy eff. date	Reviewed and Approved by _____ Date _____								HOME OFFICE USE
Date Evid. Submitted	Mo.	Day	Yr.	Cert. Issued by _____ Date _____								
BENEFICIARY CHANGES - SETTLEMENT AGREEMENT												
REQUEST DATE	RECORDED BY	RECORDED DATE	REQUEST DATE	RECORDED BY	RECORDED DATE							

HEALTH QUESTIONS

Please answer the following questions. If you answer "YES" to any questions, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your eligible dependents.

- Applicant:** Height _____ Weight _____ **Spouse:** Height _____ Weight _____
- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you or your dependents gained or lost 10 or more pounds during the past 12 months?
If "Yes," how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years:
a) Received or been advised to receive any medication, treatment, surgery, therapy, testing (except for HIV), observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health-related facility?
b) Used any illegal drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever had, been treated for, or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or your dependents pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or your dependents used tobacco in any form in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your dependents ever been treated or diagnosed as having: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years or immune system disorder?
"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure. | <input type="checkbox"/> | <input type="checkbox"/> |

Name, address and telephone no. of personal physician _____

REMARKS-If you answered "YES" to any health question above, please provide details below.

Ques. no.	First name	Description of illness, injury, or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects/ results	Name and address of attending physician or hospital (include zip)

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

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 Life Insurance Company of New York. 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 Life Insurance Company of New York. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the 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 my policy/participation agreement to remain insured. 7) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION. 8) Understand that I have the right to select any dental care provider of my choice. 9) 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.

AUTHORIZATION TO RELEASE INFORMATION: Please use form GFSLIC6 (KC2406NY). This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

Pursuant to Section 403(d) and Regular 95 of the New York State Insurance Law, the following statement applies to our accident and health policies only: "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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Employee's signature _____ Date _____

Spouse's signature (if spousal coverage) _____ Date _____