

**Employee Application**



**ASSURANT Employee Benefits**

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	Employee date of birth 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	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 _____		Employee Soc. Sec. no.	
Job title or position					State of residence	

**Status:** (If status area is not completed, we consider the employee to be active.)

Retired  Continuation  Leave of absence  Other \_\_\_\_\_

Reason \_\_\_\_\_ Date \_\_\_\_\_

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

**Employee:**  Life  Accidental Death & Dismemberment  Optional Additional Life Amt. \_\_\_\_\_

Short Term Disability  Long Term Disability Optional Amount:  STD  LTD Amt. \_\_\_\_\_

Dental

**Dependent:**  Life  Dental Please mark X in box before the dependents to be covered:  Spouse  Children

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).

Were you covered under another dental plan within the last 31 days?  Yes  No

If "Yes," termination date \_\_\_\_\_ Reason for termination of other coverage \_\_\_\_\_

**Note**— Coverages not specifically elected will not be made effective, even if not refused.

ELECTIONS NOT VALID WITHOUT SIGNATURE.

**Write** in any coverages being refused and reason for refusal.

**BENEFICIARIES** (Please read information below before completing.)

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 Insurance Company for the appropriate forms.

**Union Security Insurance Company**

Mail to: **Assurant Employee Benefits** PO Box 2939 Clinton Iowa 52733-2939