

Employee Application



ASSURANT Employee Benefits®

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.

Employee name (last, first, initial)		Employer Diocese of Helena		Employment location		
Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Job title or position	Employee hire date	# hours per week	Earnings \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other \$	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> 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	Facility ID

NOTE — Coverage not elected will be assumed refused even if not specifically refused

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

Coverage	EMPLOYEE MONTHLY COST
Employee	<input type="checkbox"/> _____
Employee + Spouse	<input type="checkbox"/> _____
Employee + Child(ren)	<input type="checkbox"/> _____
Employee + Family	<input type="checkbox"/> _____

Refuse Dental Benefits

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

Union Security Insurance Company
Mail to: Assurant Employee Benefits P.O. Box 981624 El Paso, TX 79998-1624

ISSUE

Employee name		Employer Diocese of Helena
Group policy/participant no.	Account no.	Cert. no.

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

Coverage	EMPLOYEE MONTHLY COST
Employee	<input type="checkbox"/> _____
Employee + Spouse	<input type="checkbox"/> _____
Employee + Child(ren)	<input type="checkbox"/> _____
Employee + Family	<input type="checkbox"/> _____

Refuse Vision Benefits

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. 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) 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. (6) Understand that I have the right to select any dental care provider of my choice. (7) 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. (8) Understand that coverages include waiting periods, limitations, and exclusions that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

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 _____