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 **GILMORE CONSTRUCTION CORP**	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	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	☐ _____
Employee + Spouse	☐ _____
Employee + Child(ren)	☐ _____
Employee + Family	☐ _____

☐ **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 **GILMORE CONSTRUCTION CORP**
Group policy/participant no.	Account no.	Cert. no.

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.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claim for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Employee's signature _____ Date _____