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.

Employee name *(last, first, initial)*	Employer	Employment location
	City of Springfield	**Oregon**

Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate
933039 / 2131721	158			

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.

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

Employer provided benefits—Your employer pays the premiums for the following benefits if you are eligible for them. Enrollment is automatic; no election is required.

☒ Employee Life - $10,000.00

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.

ISSUE

Employee name		Employer **City of Springfield**
Group policy/participant no. **933039 / 2131721**	Account no. 158	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 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. (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 coverages include waiting periods, limitations, exclusions and a pre-existing conditions provision 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 _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____