

### HEALTH QUESTIONS

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

**YES NO**

1. Applicant's height \_\_\_\_\_ Weight \_\_\_\_\_ Spouse's height \_\_\_\_\_ Weight \_\_\_\_\_  
 Have you or your dependents gained or lost 10 or more pounds during the past 12 months?  YES  NO  
 If "Yes," how much  Gained \_\_\_\_\_  Lost \_\_\_\_\_
  
2. Have you or your dependents within the past 5 years:
  - a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, 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?  YES  NO
  - b) Used any illegal drug?  YES  NO
  
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?  YES  NO
  
4. Have you or your dependents ever had, been medically diagnosed, treated, or been advised to seek treatment for: 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 immune deficiency syndrome (AIDS) within the past 5 years or immune system disorder?  YES  NO  
 "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Personal physician \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
NAME ADDRESS TELEPHONE NO.

Employee's address \_\_\_\_\_ Home phone ( \_\_\_\_\_ ) \_\_\_\_\_

**REMARKS AND ADDITIONAL INFORMATION FOR "YES" ANSWERS**  
 If you answered "Yes" to any medical questions 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	Name and address of attending Physician or Hospital (Include zip)

**IMPORTANT NOTICE TO APPLICANTS—PLEASE READ CAREFULLY**

**AUTHORIZATION TO RELEASE INFORMATION:** For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau or any other organization to give Union Security Insurance Company or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to Union Security Insurance Company or its reinsurers to release any information to other life insurance companies as I may come in contact with.

I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

**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) Authorize any required deductions from my earnings. 3) Designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. 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 on the effective date, or coverage will be deferred until I return to work and that dependent coverage will not become effective while the dependent is in a hospital or similar facility. 6) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION.

**NOTICE:** For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Spouse's signature (if spousal coverage) \_\_\_\_\_