



Employee Application

Please print clearly in blue or black ink.

ISSUE

Check one — Employer Use

- Initial Employee
- New Employee
- Change

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
 ↳ : Lake Zurich School District #95 :

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 : : : : Hourly Weekly Monthly Yes : Yes
 F : : : : Yearly Other : No : 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 |
|------------------------------|---------------|--------|--------------|
| | | | |
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NOTE — Coverage not elected will be assumed refused even if not specifically refused

Employee Choice Life Benefits

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

Accepts Rates Governs

- Employee Voluntary Life - Amount _____
- Employee Matching Voluntary AD&D
- Spouse Life - Amount _____
- Spouse Matching Voluntary AD&D
- Child Voluntary Life - Amount _____
- Child Matching Voluntary AD&D

Beneficiaries

| Last Name | First | MI | Relationship | |
|-----------|-------|----|--------------|--|
| | | | | <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) Beneficiaries elected will apply to all employee Life and Accidental Death and Dismemberment coverages.
- 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, please contact Union Security Insurance Company for the appropriate forms.

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.

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 _____