

FRAUD STATEMENTS

Please read the following before completing the attached form.

☞ If you live in the states of Arkansas or Louisiana, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☞ If you live in the state of California, the following statement applies to you:

For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

☞ If you live in the state of Colorado, the following statement applies to you:

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

☞ If you live in the District of Columbia, the following statement applies to you:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

☞ If you live in the state of Florida, the following statement applies to you:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

☞ If you live in the state of Maryland or Oregon, the following statement applies to you:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

☞ If you live in the state of New Jersey, the following statement applies to you:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

☞ If you live in the state of Virginia, the following statement applies to you:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

☞ If you live in a state other than mentioned above, the following statement applies to you:

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.

To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the pages.

Union Security Insurance Company

Mail to: **Assurant Employee Benefits** PO Box 419596 Kansas City Missouri 64141-6596

T 816.474.2345

Form 1 (8/04)

Group Insurance Preliminary Application



Policy no. _____

UNDERWRITING COMPANY: UNION SECURITY INSURANCE COMPANY (THE COMPANY)
(WE, US OR OUR WHEN USED HEREIN REFER TO THE COMPANY.)

APPLICANT INFORMATION (You and your when used herein refer to Applicant.)

1. Exact legal name... 2. Full address and contact numbers of main office... 3. Correspondent's name and title... Note: The contract will be issued in the state where the main office is located unless otherwise requested and approved.

APPLICANT'S BUSINESS INFORMATION

4. Nature of business... 5. Business is organized as: Corporation, Partnership, Proprietorship... 6. Financial Status (If you answer yes to any part, please provide explanation below.)

AFFILIATE OR SUBSIDIARY INFORMATION

7. Indicate any affiliates or subsidiaries to be covered. An affiliate or subsidiary is a separate firm owned or controlled by the Applicant. Its employees will be insured under the policy **only** if requested below and approved by the Company. Please complete all the requested information for each affiliate or subsidiary to be covered under the policy. See question 5 for business type.

Name

Address

Nature of Business Business Type SIC Code

No. of Employees Percentage owned by Applicant

Name

Address

Nature of Business Business Type SIC Code

No. of Employees Percentage owned by Applicant

Name

Address

Nature of Business Business Type SIC Code

No. of Employees Percentage owned by Applicant

Is separate billing required? Yes No If "Yes," give complete details in question 12 of this application.

8. Coverages requested and effective date of coverage(s) (Please specify if dates differ by coverage.)

Life and Accidental Death & Dismemberment Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees/ Dependents	No. of Participating Employees/ Dependents
<input type="checkbox"/> Employer Paid (with matching AD&D)	_____	_____	_____
<input type="checkbox"/> Employer Paid (without AD&D)	_____	_____	_____
<input type="checkbox"/> Additional Contributory Life	_____	_____	_____
<input type="checkbox"/> Dependent Life	_____	_____	_____
<input type="checkbox"/> Voluntary Life (with matching AD&D)	_____	_____	_____
<input type="checkbox"/> Voluntary Life (without AD&D)	_____	_____	_____
<input type="checkbox"/> Voluntary Dependent Life	_____	_____	_____

For Voluntary Life, indicate the number of eligible males _____ eligible females _____

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? Yes No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently making application for any similar group insurance program? Yes No If "Yes," please explain. _____

Short and Long Term Disability Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees	No. of Participating Employees
<input type="checkbox"/> Employer Paid Short Term Disability	_____	_____	_____
<input type="checkbox"/> Employer Paid Long Term Disability	_____	_____	_____
<input type="checkbox"/> Voluntary Short Term Disability	_____	_____	_____
<input type="checkbox"/> Voluntary Long Term Disability	_____	_____	_____

Are any of your employees eligible for a State Disability Plan? Yes No If "Yes," which state(s) _____

Do you provide salary continuance or any kind of income replacement plan (formal or informal) other than the coverages requested above? Yes No If "Yes," which of the following best describe the plan? Check all that apply:

Salary Continuance Short Term Disability Long Term Disability Other (Please describe.) _____

Do you or can your employees elect to "gross up" (include as taxable income) the cost of disability coverage? Yes No

Will the plan(s) requested replace other coverages as of the effective date of our coverage, if approved? Yes No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently making application for any similar group insurance program? Yes No If "Yes," please explain. _____

Dental Insurance

Check all that apply and complete required fields	Employer Contribution %	No. of Eligible Employees/ Dependents	No. of Participating Employees/ Dependents
<input type="checkbox"/> Employer Paid Dental	_____	_____	_____
<input type="checkbox"/> Dependent Dental	_____	_____	_____
<input type="checkbox"/> Voluntary Dental	_____	_____	_____
<input type="checkbox"/> Voluntary Dependent Dental	_____	_____	_____

Will the plan(s) requested replace other coverage as of the effective date of our coverage, if approved? Yes No

If "Yes," please provide a copy of prior carrier contract and bill. If "No," please explain. _____

Are you currently making application for any similar group insurance program? Yes No If "Yes," please explain. _____

Other* (must also purchase a fully insured product)

Employee Assistance Program Select type: Phone and Online In Person Assessment Short Term Counseling

 If elected, complete form KC3325 Employee Assistance Program Agreement.

Healthy Solutions Discount Card If elected, please complete the Healthy Solutions Group Information form.

* Products provided by third-party vendors under separate agreements with Applicant.

BILLING AND ADMINISTRATION

9. Do you have a Section 125 Plan? Yes No **If "No," please proceed to question 10.**
Will any of the requested coverages be part of the Section 125 Plan? Yes No
If "Yes," please indicate whether contributions are: Post-tax Pre-tax Post or Pre-tax at individual election
If any part of the contributions are post-tax, please indicate the percentage of premium paid post-tax _____ %.
Open Enrollment Period for Section 125 Plan _____ Please note, Life Events will be defined per our standard language unless a copy of your 125 Plan is submitted for review and approval.
Section 125 Plan included? Yes No

10. Who will bill the coverages requested?
 The Company (with online administration included at no cost)
 Policyholder (Self-Administration) If this option is selected, the Company can prepare the initial bill for all employer paid coverages. Do you want the Company to prepare the initial bill? Yes No
For Self-Administration you must agree to provide a complete census to the Company upon request and at least once a year.
 Third Party Administrator **Note: TPA must be approved by the Company prior to submitting case and Applicant must complete and submit form KC2691, Appointment of Third Party Administrator.**

11. Premium is to be billed: Monthly Quarterly Semi-annually Annually
Additional options for Voluntary coverages: Weekly Bi-weekly Semi-monthly

12. Are separate billing accounts required? Yes No If "Yes," provide name, address and contact name for each.

If more space is needed, please provide an attached list and indicate here that an attachment exists. Attachment

13. For Life Insurance, will you maintain beneficiary information? Yes No If "Yes," you must agree to maintain all records pertaining to the beneficiary of life insurance and all subsequent beneficiary changes. Note: All assignments or irrevocable designations must be submitted to the Company for review and approval, accompanied by the original enrollment form.
If you are not maintaining beneficiaries you must agree to submit the original enrollment form and all subsequent beneficiary changes to the Company.

14. The following applies to **all** coverages unless otherwise stated.
A. Service Requirement for current employees (hired on or before the effective date) _____ Days Months

B. Service Requirement for future employees (hired after the effective date) _____ Days Months

C. Entry date: Immediate 1st of the month occurring on or after First of the payroll cycle (*Voluntary dental only*)
 Other (*Specify.*) _____

Note: For Voluntary coverages entry date cannot be immediate.

D. Full-time definition: Standard (30 hours for employer paid, 20 hours for Voluntary coverages)
 Other (*requires Home Office approval*). Please specify request _____
E. Effective date for changes due to salary changes for **employer paid** coverages Immediate Policy Anniversary
 1st of month occurring on or after Other (*Specify.*) _____
F. Effective date for changes due to salary changes for **Voluntary** coverages Immediate Policy Anniversary
 Other (*Specify.*) _____
G. Effective date for changes due to age for **employer paid** coverages Immediate Policy Anniversary
 1st of month occurring on or after Other (*Specify.*) _____

- H. Effective date for changes due to age for **Voluntary** coverages Policy Anniversary
 Other (Specify) _____
- I. Termination date for Dental coverage Immediate (not available for Voluntary dental)
 End of the payroll cycle (Voluntary dental only) End of the month in which employment terminates.
- J. Annual enrollment _____ (Should coincide with applicant's medical plan or 2 months prior to Policy Anniversary.)

CERTIFICATE AND CONTRACT INFORMATION

15. Certificates are provided in electronic format for all coverages. Please review the following statement regarding your responsibilities in relation to electronic certificates.
Significance: Electronic Certificates ("e-certs") provide important information about insurance coverage and protection for insureds under the policy. You must agree that you will: (1) Distribute e-certs to insureds under the policy; (2) not release or otherwise transfer e-certs to third parties (other than insureds), without the Company's prior written approval; (3) not alter, modify or otherwise change e-certs and will ensure that adequate security is in place to prevent insureds from doing the same; (4) take measures to ensure that the system furnishing e-certs results in actual receipt of the information by each insured (use return-receipt electronic mail features or periodic review/surveys to confirm receipt) and (5) convey to each insured the **significance** of e-certs, that the certificate is being furnished electronically and that the insured may request and receive a paper copy at no charge.
- If you are unable to comply with e-cert responsibilities, check here and paper certificates will be provided to you.
16. Summary Plan Description (SPD): ERISA Plan Information. ERISA requires employers to distribute SPD's for most employer-sponsored benefit plans. To the best of our knowledge, the certificate can serve as your SPD if certain plan information and a statement of ERISA rights are provided with the certificate.
- Should we include ERISA information for an SPD? Yes No If "Yes," supply the following information.
- Name of the plan _____
- If other than the policyholder, please provide the full name, address and phone number of the:
- Plan sponsor _____
- Plan administrator _____
- Agent for service of legal process _____
- Plan number(s) _____ Note: the plan number is PN501 unless another number is assigned by the employer or the Plan Administrator.

EMPLOYEE INFORMATION AND VERIFICATION

17. Employees at active work
 Applicant certifies that all employees are at active work at their usual place of business on date signed on page 6.
 There are employees who are not at active work at their usual place of business on date signed on page 6. They are listed below.
- | Name | Date of Birth | Age | Insurance Amount | Nature of Illness or Reason for Absence |
|-------|---------------|-------|------------------|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
18. Are any employees located outside the United States? Yes No If "Yes," please provide the name of the employee(s), location and country of citizenship. Advise how long the employees will be located outside the United States.
- _____
- _____
- _____
- Please note, employees working outside the United States are not covered by the policy unless agreed to, in writing, by the Company.**
19. If this Preliminary Application is being signed after the requested effective date, you must complete the following:
 Applicant certifies that there have been no claims incurred since the requested effective date and Applicant is unaware of any changes in medical condition or status.

APPLICANT AGREEMENT

- A. \$ _____ has been paid by the Applicant to be applied toward the first premium due for coverages requested in this Preliminary Application. This amount will be returned if the requested insurance does not become effective. Cashing of the check by the Company is not acceptance and approval of this Preliminary Application.
- B. The Applicant certifies that the information contained herein is true and correct to the best of the Applicant's knowledge and belief and understands that it forms the basis for its request for insurance. Omission or misstatement of known information on this Preliminary Application could affect the validity of any insurance issued and cause denial of a claim.
- C. The Applicant understands that the requested insurance will:
 - 1. Be issued only if the requested insurance is acceptable to the Company and is legally permissible;
 - 2. Be issued under a group policy(ies) in the language customarily used by the Company;
 - 3. Be subject to the Company's usual underwriting requirements (including evidence of insurability, if applicable);
 - 4. Take effect on the date determined by the Company; and
 - 5. Not be effective until this Preliminary Application is approved and accepted by the Home Office of the Company in Kansas City, MO.
- D. The Applicant understands that no agent or broker has the authority to accept or guarantee acceptance of the requested insurance.
- E. The Applicant understands that this Preliminary Application may be a request to participate in the Company's Small Group or Voluntary Trust Plans as determined by the Company's underwriting rules. If this item E applies and the Company approves and accepts this Preliminary Application, Applicant agrees to be bound by the terms of the group policy(ies) issued to the Trustees of the applicable Trust Plans.
- F. The Applicant agrees to offer the requested insurance to all of its eligible employees.
- G. The effective date of the requested insurance for which an employee is required to submit evidence of insurability will be determined in accord with the group policy's terms and will be subject to the active work requirement. The Applicant agrees not to:
 - 1. Collect or pay premiums (other than the initial deposit) for such insurance before receiving the Company's approval notice; and
 - 2. Distribute material describing the policy coverage to persons to be insured without the Company's prior written consent.
- H. The requested coverage provides benefits for the employee welfare benefit plan established and maintained by the employer - Applicant under the Employee Retirement Income Security Act (ERISA), unless otherwise exempted by law.
- I. If the requested insurance is approved and accepted, that insurance will automatically terminate if the premiums are not paid before the end of the grace period following the due date. Payment of premiums for coverage during the grace period is required. Insurance coverage will terminate if the number or percentage of participants falls below that required by the group policy.
- J. No one except the President, Senior Vice President or Chief Financial Officer of the Company may make, alter or discharge contracts or waive any of the Company's rights or requirements.

Applicant's Signature _____ Print name _____

Title _____ Date (required) _____

Company's representative _____ Date _____

PRODUCER INFORMATION

1. Individual or firm (*legal name*) _____

Writing agent of firm _____

Address _____

City/State/ZIP _____

E-mail address _____

Phone no. _____ Fax no. _____

Payee no. _____ Production Split _____%

License no. _____

Producer _____

Signature _____ Date _____

2. Individual or firm (*legal name*) _____

Writing agent of firm _____

Address _____

City/State/ZIP _____

E-mail address _____

Phone no. _____ Fax no. _____

Payee no. _____ Production Split _____%

License no. _____

Producer _____

Signature _____ Date _____

Note: Agent/Broker must note his/her license number for contract state.