ASSURANT EMPLOYEE BENEFITS

Underwritten by: UNION SECURITY INSURANCE COMPANY
Administrative Office: One Riverfront Plaza, Westbrook, ME 04092-9700

EMPLOYEE APPLICATION FOR GROUP DISABILITY INSURANCE (LTD & STD)

To enroll, complete in ink and return to your Agent or Employer.

Shaded Areas for Office Use Only.

Group Number: 3 0 5 0 2	Division Number:	Class Number:	Agent Number:
Last Name (Please Print) First Middle Initial	Birth Date (Mo. Day. Yr.)	Social Security No.	
Home Address - Street (Please Print)	City	State	Zip Code
Home Phone Number ( )	E-mail Address:	Annual Income $	Sex ☐ Male ☐ Female
Employer Name Sabine ISD	Location	Occupation	Date Employed / Hours Worked per Week
Number of Salary Deductions/Year:			
Will the coverage applied for with this application replace any existing disability income coverage? ☐ Yes ☐ No			
Will the coverage applied for with this application be in addition to another disability income coverage? ☐ Yes ☐ No			

Check Boxes that Apply	Select Coverages desired Or to be Changed	Elimination Period	Benefit Duration	Benefit Amount	Premium/Rate
☐ New Enrollment ☐ Change In Coverage	☐ Short Term Disability (STD)			$	
	☐ Long Term Disability (LTD)			$	
	Effective Date	First Deduction Date			Total Deduction/ Premium Rate $

I am enrolling for insurance in accordance with the terms of the policy for which I am eligible. By signing this application, I the undersigned, to the best of my knowledge and belief, represent that I am now in good health and free from physical impairment (except for those items indicated on this application), and I represent that all the answers are true and complete, and I understand that the proposed insurance will not become effective unless and until the Company approves this application and initial premium is received. I understand that any false statements or misrepresentations in this application may result in loss of insurance, if such false statements materially affected either the acceptance of the risk or the hazard assumed by the Company.

If a health questionnaire is not required, I agree that the effective date will coincide with the period covered by my initial premium payment. The Company reserves the right to change the effective date stated above if necessary. No insurance will be effective for any policy for which all eligibility requirements have not been met.

I authorize the Payroll Department to deduct my initial and renewal premium contribution from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction.

I understand that in order to revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions and abide by any rules specified by the employer's benefit plan and/or by law.

Dated at: _____ On: _____
City State Month Day Year

_____ _____
Signature of Employee Printed Name of Employee