

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:			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 <input type="checkbox"/> Male <input type="checkbox"/> Female				
Employer Name Spring Hill 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?										<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the coverage applied for with this application be in addition to another disability income coverage?										<input type="checkbox"/> Yes <input type="checkbox"/> No	
Check Boxes that Apply	Select Coverages desired Or to be Changed			Elimination Period		Benefit Duration	Benefit Amount		Premium/Rate		
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Short Term Disability (STD)						\$				
<input type="checkbox"/> Change In Coverage	<input type="checkbox"/> 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

EVIDENCE OF INSURABILITY - If any question below is answered "YES", give reason and provide details as to the nature of the ailment, medications, date of onset and duration of treatment and indicate if recovery was complete in the "Degree of Recovery" column. *If more space is needed, please provide the additional information on a separate signed and dated sheet.*

YOUR ANSWERS TO THE FOLLOWING QUESTIONS ARE PART OF YOUR APPLICATION FOR INSURANCE. THEY MAY BE USED TO DETERMINE YOUR ELIGIBILITY FOR ANY BENEFITS CLAIMED. *PLEASE READ THE QUESTIONS AND ANSWER CAREFULLY.*

- a. Within the past 10 years, have you had a diagnosis for or treatment for:
 Arthritis, back, knee, bone or joint condition, chronic fatigue or chronic pain, asthma, emphysema, or other lung disorder, cancer or tumor, colitis, diverticulitis or other digestive system disorder, diabetes, high blood pressure, heart or circulatory system disorder, disorder of the reproductive organs, drug or alcohol problems, kidney or other urinary system disorder, liver, spleen or pancreas disorder, enlarged lymph nodes, mental or nervous problems, or any condition not listed above that you have a consultation for or treatment recommended by a medical practitioner? **(Please circle conditions and give details below on these or any unlisted conditions.)**
- b. Please list any medications you are currently taking and the medical diagnosis for their use.

- c. Within the past 10 years, has surgery been advised or discussed but NOT PERFORMED? Yes No
- d. Have you ever been treated for or diagnosed with any disease or disorder of the Immune System including Acquired Immunodeficiency Syndrome (AIDS), Acquired Immunodeficiency Syndrome Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? Yes No
- e. Are you currently pregnant? Yes No
- f. What is your height? _____ Feet _____ inches Weight? _____ pounds
- g. Within the past 2 years, have you been absent from work 5 or more consecutive days due to injury or illness? Yes No

PLEASE PROVIDE COMPLETE DETAILS TO ALL "YES" ANSWERS BELOW

Question Letter	Diagnosis (Ailment)	Date of Onset	Treatment and Dates of Treatment	Degree of Recovery And/or Control

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.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and Union Security Insurance Company *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, Union Security Insurance Company and the above-described representatives to evaluate my application for disability insurance, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Disability RMS or Union Security Insurance Company solely to assist with this purpose. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization will remain in effect a maximum of six (6) months from the date of the signature below. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I or my authorized representatives have the right to revoke this authorization by notifying Disability RMS in writing. However, such revocation is not effective to the extent that Disability RMS and/or Union Security Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my application for disability insurance coverage.

DECLARATION of APPLICANT GIVING STATEMENT OF INSURABILITY

- To the best of my knowledge and belief, all statements made on this application are true and complete.**
- I understand that my application for insurance will be accepted or declined on the basis of these statements.**

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

 Signature of Employee Printed Name of Employee

**ASSURANT EMPLOYEE BENEFITS – EDUCATOR PRODUCT
PRODUCTS UNDERWRITTEN BY UNION SECURITY INSURANCE COMPANY**

PROOF OF GOOD HEALTH ACKNOWLEDGEMENT

EMPLOYER NAME: Spring Hill ISD

**THIS FORM IS REQUIRED IF YOU ARE APPLYING FOR AMOUNTS THAT
REQUIRE PROOF OF GOOD HEALTH:**

I understand that any amount of insurance I have applied for on myself or my dependents that is subject to proof of good health is not effective or in force until and unless:

- The insurance requiring proof of good health is approved by Union Security Insurance Company;
- Initial premium is received; and
- All eligibility requirements are met.

If any or all of the insurance requiring proof of good health is disapproved by Union Security Insurance Company you will be notified and any premiums paid will be refunded to you.

The certificate of insurance will be the sole notice of such approved amount of insurance.

Employee name

Print

Signature

Date _____