Employee Application

Please print clearly in blue or black ink.

ISSUE

ASSURANT Employee Benefits®

Check one – Employer Use

☐ New Employee ☐ Change ☐ COBRA

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 Harrisonburg City Public Schools	Employment location

Group policy/participant # 5451578	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate

Sex ☐ M ☐ F	Job title or position	Employee hire date	# hours per week	Earnings $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other $_____	Married ☐ Yes ☐ No	Children ☐ Yes ☐ 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

NOTE — Coverage not elected will be assumed refused even if not specifically refused

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

Coverage	EMPLOYEE MONTHLY COST	Coverage	EMPLOYEE MONTHLY COST
Employee	☐ _____	Employee + Child(ren)	☐ _____
Employee + Spouse	☐ _____	Employee + Family	☐ _____

☐ Refuse Vision Benefits

Union Security Insurance Company
Mail to: **Assurant Employee Benefits**: P.O. Box 981624 El Paso, TX 79998-1624

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Employee name	Employer **Harrisonburg City Public Schools**	
Group policy/participant no.	Account no.	Cert. no.

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 Compa (3) Authorize any required deductions from my earnings. (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 the numb hours specified in the policy/participation agreement to remain insured.

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

Do you have existing life insurance? ☐ Yes ☐ No

Employee's signature _____ Date _____

FOR AGENT/BROKER: Does the employee have existing life insurance? ☐ Yes ☐ No

Signature _____ Date _____