Employee Application

Please print clearly in blue or black ink

Check one – Employer Use

◉ Open Enrollment ◯ 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.

Employer	Group/Policy #	Employment Location	Effective Date
Southern Medical Corporation	**923154**	Admin (000)	

* Gender: ☐ M ☐ F	Last Name	First Name	MI	Date of Birth	Social Security Number

Street Address, City, State, Zip Code	Email Address

COMPLETED BY EMPLOYER:

Job Title / Position	Date of Hire	Earnings	Hours per week: _______
		$	☐ Hourly ☐ Weekly ☒ Bi-Weekly ☐ Yearly

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

* **DEPENDENT INFORMATION** *(Required if dependent coverage applies)*

	Gender	Relationship	Name (Last, First)	Date of Birth	Social Security Number
☐ Add ☐ Terminate ☐ Change	☐ Male ☐ Female	☐ Spouse ☐ Child			
☐ Add ☐ Terminate ☐ Change	☐ Male ☐ Female	☐ Spouse ☐ Child			
☐ Add ☐ Terminate ☐ Change	☐ Male ☐ Female	☐ Spouse ☐ Child			
☐ Add ☐ Terminate ☐ Change	☐ Male ☐ Female	☐ Spouse ☐ Child			

Note – Coverage not elected will be assumed "waived" even if not specifically indicated.

* **BENEFIT ELECTIONS** *(Check at one box per benefit in the rows below)*

	Member Only	Member + Dependent(s)	WAIVE / DENY	Bi-Weekly Premium
DENTAL	☐	☐	☐	**$**
VISION	☐	☐	☐	**$**

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. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant Limitation period specified in the policy (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 number of hours specified in the policy/participation agreement to remain insured (6)Understand that I have the right to select any dental care provider of my choice (7)Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed (8)Understand that coverages include waiting periods, limitation, and exclusions that may affect my entitlement to benefits. 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 presents a false or fraudulent claim for payment of 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.

EMPLOYEE SIGNATURE: ____ **TODAY'S DATE:** ____________________