

# Employee Application



## ISSUE

### Check one – Employer Use

Initial Employee       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.

Employee name ( <i>last, first, initial</i> )		Employer <b>Greenbush Health</b>			Employment location	
Group policy/participant no.		Account no.	Cert. no.	Employee SSN	Employee birthdate	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Job title or position	Employee hire date	No. hours Per week	Earnings \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> 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)	SSN	Date of Birth	Gender	Relationship

**Voluntary Life Benefits** – You will pay 100% of the premium for the following benefits if you choose to enroll.

<b>Accept</b>	<b>Refuse</b>	<b>Coverage</b>
<input type="checkbox"/>	<input type="checkbox"/>	Employee Life/AD&D – Amount _____
<input type="checkbox"/>	<input type="checkbox"/>	Spouse Life – Amount _____
<input type="checkbox"/>	<input type="checkbox"/>	Child Life – Amount _____

### BENEFICIARIES

Last name	First	Mi	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.  
 1) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee Life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 5) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

**ISSUE**

Employee name		Employer <b>Greenbush Health</b>
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 Company. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.**

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_