Union Security Insurance Company

Please:
1. Fully review the plan description literature, noting these benefits which are subject to Evidence of Insurability and complete the Health Questionnaire when necessary. Be sure to provide Details and dates.
2. Complete all unshaded sections, using a ball point pen and writing on a hard surface.

Shaded Areas for Office Use Only

Group ID: FL 1 5 2 1 0 T	Division ID: 0 5 7	Class Code:		
Last Name (Please Print) First MI	Birth Date (Mo/Day/Yr.)	Sex ☐ M ☐ F	Social Security No.	
Home Address – Street (Please Print)	City	State	Zip Code	
Phone Number ( )	Date of Employment	Annual Salary	Present School District **PINELLAS COUNTY SCHOOLS**	District Last Year
Name of School	Position	Are you employed on A full-time basis? ☐ YES ☐ NO	Are you actively at work full-time On the date of this enrollment? ☐ YES ☐ NO	
Beneficiary and Relationship				

Check Boxes that Apply	Select Plan(s) or Coverages Desired or to be continued	Benefits Without Evidence of Insurability			Benefits Requested (Complete Health Questionnaire on the back of this form if needed)		
☐ New Enrollment ☐ Change in Coverage (List all coverages to be continued under selected Plan(s))		Benefit Amount		20 Salary Deductions Per Year	Benefit Amount		20 Salary Deductions Per Year
	☐ Short Term Disability ☐ 16 ☐ 31 ☐ 61	$			$		
	☐ Long Term Disability	$			$		
	FMP G.I. / FMP EVID.	Eff. Date	First Deduction	Total Deduction	Eff. Date	First Deduction	Total Deduction

H.O. Evidence Approval Initials: Date:	Evidence Entry Initials: Date:	G.I. Entry Initials: Date:

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 Union Security Insurance 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 Union Security Insurance 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. Union Security Insurance 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 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 Union Security Insurance Company, and are to be paid to Union Security Insurance 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. I understand that the insurance applied for contains exclusions and limitations.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed_________________________ Dated ___________ Licensed Resident Agent _____________License # ______

PLEASE COMPLETE THE HEALTH QUESTIONNAIRE ON BACK OF THIS FORM IF NEEDED.

HEALTH QUESTIONNAIRE – If any question below is answered "YES", underline the condition. 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 "REMARKS" column. If more space is needed for "REMARKS" (Details and Dates), use the reverse side of this page.			
Height_____ Ft. _____ Inches Weight _______ Lbs.			REMARKS (Details, Medications and Dates)
1. Have you to the best of your knowledge and belief, ever had or been told that you had, or been treated for any of the following: (Underline the condition and record details in space provided) Heart trouble, high blood pressure, diabetes, cancer, digestive disorder, respiratory disease, kidney disease, nervous or mental disorder, alcoholism, drug addiction, generalized enlarged lymph nodes or immune deficiency disorder except AIDS or ARC?	YES	NO	
2. During the past 5 years, have you received medical care or surgical treatment, undergone an operation or been hospitalized (including pregnancy)? List any complications of pregnancy.			
3. Do you contemplate any operation or visit to a doctor for any existing injury or illness (including pregnancy)?			
4. Have you made a claim for or received benefits or income due to an injury or illness in the past 5 years?			
5. Are you currently pregnant?			
6. Have you been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other illness or condition derived from such infection?			

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 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 any organization or person, employed by or representing Disability RMS 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 pursuant to this authorization, and as a result, may be the basis for denying insurance or during a contestability period under applicable law. Failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my application and as a result may be a basis for denying my application for disability insurance coverage.

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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

__________________________________ __________________________

Signature of Employee Date

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.