

COMPANY
NAME
DOB
LOCATION

Columbia College

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 Columbia College			Employment location	
Group policy/participant no. 4032385		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

Employer provided benefits—Your employer pays the premiums for the following benefits if you are eligible for them. Enrollment is automatic; no election is required.

- Long Term Disability

Employer provided contributory benefits—You may select any of the benefits below. If you enroll, you will pay a portion of the premium.

- | Accept | Refuse | Coverage |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Employee Dental |
| <input type="checkbox"/> | <input type="checkbox"/> | Dependent Dental - Spouse |
| <input type="checkbox"/> | <input type="checkbox"/> | Dependent Dental - Child |

Were you covered under another dental plan within the last 31 days? Yes No

If "Yes," termination date _____ Reason for termination of coverage _____

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

- | Accept | Refuse | Coverage |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Employee Life – Amount _____ |
| | | • Do you wish to purchase the matching Accidental Death and Dismemberment? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | • Have you used tobacco products regularly in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Spouse Life – Amount _____ |
| | | • Has your spouse used tobacco products regularly in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Child Life – Amount _____ |

Union Security Insurance Company

Mail to: Assurant Employee Benefits P.O. BOX 2939 Clinton, IA 52733-2939

ISSUE

Employee name		Employer Columbia College
Group policy/participant no. 4032385	Account no.	Cert. no.

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.

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. 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) 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. (7) Understand that I have the right to select any dental care provider of my choice. (8) 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. (9) Understand that the short term disability plan/long term disability plan includes limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

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.

Employee's signature _____ Date _____

Employee Health Statement

Employee name <i>(last, first, initial)</i>			Employer Columbia College	
Group policy/participant no. 4032385	Account no.	Cert. no.	Employee SSN	Employee birthdate

New Enrollee Annual Enrollment Life Event-Type/Date _____

Please answer the following questions. If you are applying for dependent coverage, please answer all questions for your eligible dependents. Applicant's Height _____ Weight _____ Spouse's Height _____ Weight _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you or your dependents gained or lost 10 or more pounds in the past 12 months?
If yes, how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years: | | |
| a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Used any illegal drug? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or your dependents pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or your dependents used tobacco, in any form in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your dependents ever had, been medically diagnosed, or treated for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years or immune system disorder?
"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure. | <input type="checkbox"/> | <input type="checkbox"/> |

Name, address and telephone number of personal physician _____

Employee's address _____ Daytime phone (_____) _____

**If you answered "YES" to any questions, please provide details in REMARKS below.
Elections are not valid without a signature at the end of this application.**

REMARKS

If you answered "Yes" to any medical questions above, please provide details below:

Question no.	First name	Description of illness injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending physician or hospital (including zip)

Union Security Insurance Company

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Employee name		Employer Columbia College
Group policy/participant no. 4032385	Account no.	Cert. no.

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

To properly underwrite applications and issue insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics and information. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, Missouri 64108.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer or any other organization to give UNION SECURITY INSURANCE COMPANY or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to UNION SECURITY INSURANCE COMPANY or its reinsurers to release any information to other life insurance companies as I may come in contact with. I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

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) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
- (4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
- (5) Understand that the short term disability plan/long term disability plan includes limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

This will certify that I HAVE read and understand the above important notice.

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.

Employee's signature _____ Date _____

Spouse's signature (if spouse coverage elected) _____ Date _____