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 Number	Employment Location	Effective Date
Southern Medical Corp			

Gender ☐ Male ☐ Female	Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City, State, Zip	Phone Number	Email Address

COMLETED BY EMPLOYER:

Job Title or Position	Hire Date	☐ Full Time ☐ Part Time	Earnings $_____ Hours per week: _____ ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Yearly

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.
DEPENDANT INFORMATION – Required if Dependant coverage applies

DEPENDENT INFORMATION

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

NOTE – Coverage not elected will be assumed refused even if not specifically refused.

BENEFIT ELECTIONS *(Must check at least one of the boxes below)*

	Member Only	Member & Family	WAIVE / DENY	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: _____**