

Employee Application

Please print clearly in blue or black ink.

RENEWAL

Check one – Employer Use

New Employee Change COBRA

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 Avery County Schools			Employment location	
Group policy/participant # 605394	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Job title or position	Employee hire date	# 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)	Date of Birth	Gender	Relationship

NOTE — Coverage not elected will be assumed refused even if not specifically refused

DENTAL BENEFITS— You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Accept	Refuse	Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Employee
<input type="checkbox"/>	<input type="checkbox"/>	Employee + Spouse

Accept	Refuse	Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Employee + Child
<input type="checkbox"/>	<input type="checkbox"/>	Employee + Family

Refuse Dental Benefits

RENEWAL

Employee name		Employer Avery County Schools
Group policy/participant no. 605394	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. 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, limitations, exclusions and a pre-existing conditions provision 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.

No statement made by you or by you on behalf of a dependent about insurability will be used to deny a claim for a loss incurred after coverage has been in effect for 2 years.

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the *policy* and recovery of any amounts we have paid. Pursuant to NCGS 58-2-161(b), any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____