Accident Only Portability Employee Application

ASSURANT Employee Benefits®

FRAUD STATEMENTS

Please read the following before completing the attached form.

If you live in the states of Arkansas, Louisiana or Rhode Island, the following statement applies to you:
Any person who knowingly presents a false or fraudulent claim for payment of a 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.

If you live in the state of California, the following statement applies to you:
For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in the state of Colorado, the following statement applies to you:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you live in the District of Columbia, the following statement applies to you:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

If you live in the state of Florida, the following statement applies to you:
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.

If you live in the state of Kansas, the following statement applies to you:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

If you live in the state of Kentucky, the following statement applies to you:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

If you live in the state of Maryland, the following statement applies to you:
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of New Hampshire, the following statement applies to you:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

If you live in the state of New Jersey, the following statement applies to you:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

If you live in the state of Oregon, the following statement applies to you:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

If you live in the state of Virginia, the following statement applies to you:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

If you live in a state other than mentioned above, the following statement applies to you:
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.

***To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the* pages.**

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This form must be fully completed including employer signature line, for accurate and timely processing.

A. Employee information

Name _____
LAST FIRST MI

Date of birth _____ Certificate no. _____ Social Security no. _____

Date of termination _____ Reason for termination _____

B. Employer information

Group policy no. _____

Employer's name, address and telephone no. _____

C. Employee portability information

I wish to continue accident only insurance on: ☐ Myself ☐ Myself / my dependent(s)

Name(s) of dependent(s) to be continued:

Spouse _____ Date of birth _____

Child(ren) *(If additional space is needed, please attach list.)*

1. _____ Date of birth _____

2. _____ Date of birth _____

D. Beneficiary for portable certificate

_____
BENEFICIARY NAME RELATIONSHIP

E. Billing information and deposit premium

Applicant's home address _____ (_____) _____
STREET ADDRESS APT. NO. TELEPHONE NO.

_____
CITY STATE ZIP

Billing mode requested: ☐ Monthly ☐ Annually

Premium submitted $ _____ *(Must equal initial modal premium or 2 modal premiums for monthly billing; call toll free 866.909.6065, for premium rates.)*

Note: All checks must be drawn to the order of Union Security Insurance Company, and if accepted, are subject to collection.

Applicant's signature _____ Date _____

To be completed by Employer

I have reviewed all of the information above and certify that it is correct to the best of my knowledge.

_____ _____ _____
SIGNATURE OF EMPLOYER TITLE DATE

NOTICE OF PORTABILITY
ACCIDENT ONLY INSURANCE

Employee Portability:

As a covered employee, if your insurance has ended for a reason other than you did not pay your share of the premium, you may be eligible to continue your plan of group accident only insurance and dependent accident only insurance. Please refer to your certificate of insurance from your Group Accident Only policy for details regarding your eligibility to exercise the portability option.

You may not add or increase any amounts of insurance once you are eligible for or elect portability. All other provisions of the certificate *(including all benefits, limitations and exclusions)* will continue to apply. Please refer to the certificate for complete coverage information.

In order to continue your insurance, you must send Union Security Insurance Company the completed Portability Application on page 3 of this form within 31 days of your termination of insurance. In addition, you must also submit your first modal premium to us with this application (or two modal premiums for monthly billing). To determine the initial premium required, call toll free 866.909.6065 for a quote. Upon approval, your certificate will become effective on the day following date of termination with no break in coverage.

Your portable term certificate will continue for as long as you continue to pay the modal premium, until the later of the day before your 65th birthday or 12 months from the date your coverage under the original group accident only insurance policy ends.

Mail your completed Portability Application and initial premium to:

Union Security Insurance Company
c/o Assurant Employee Benefits
PO Box 219304 Kansas City, MO 64121

T 866.909.6065