Union Security Life Insurance Company of New York
Extended Employee Application

(Please complete the health questions on the reverse side of this application.) G. O. no. ________

Group policy/participant no.	Account no.	Cert. no.	Employer	Employment location/phone no.

Employee name *(last, first, initial)*	Part-time employ. date Month Day Year	Full-time employ. date Month Day Year	Sex ☐ M ☐ F	Married ☐ Yes ☐ No	Children ☐ Yes ☐ No

Employee date of birth Month Day Year	Earnings ________ ☐ Hourly No. hrs. per week ____ ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other ________	Job title or position	State of residence	Employee Soc. Sec. no.

Status: *(If status area is not completed, we consider the employee to be active.)*
☐ Retired ☐ Continuation ☐ Leave of absence
Reason ________________ Date ________

Employee home address and phone no.
( )

Please mark **X** in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: ☐ Basic Life ________ ☐ Optional Additional Life ________ Amount in force ________
☐ Accidental Death & Dismemberment ________
☐ Short Term Disability ☐ Optional Additional STD ________ Amount in force ________
☐ Long Term Disability ☐ Optional Additional LTD ________ Amount in force ________
☐ Dental

Dependent: **Please** mark **X** in box before the dependents to be covered: ☐ Spouse ☐ Children
☐ Dependent Life ________ Amount in force ________
☐ Optional Additional Dependent Life ________ Amount in force ________
☐ Dependent Dental

Note—Coverages not specifically elected will not be made effective, even if not refused.
ELECTIONS NOT VALID WITHOUT SIGNATURE.

Were you covered under another dental plan within the last 31 days? ☐ Yes ☐ No
If "Yes," termination date ________ Reason for termination of other coverage ________

If spouse coverage is being applied for, complete the following.

Name of Spouse	Date of Birth Month Day Year	Social Security No.	Employer	Current Dental Insurance Carrier

Write in the names and dates of birth of children to be covered *(subject to plan provisions)*.

Write in any coverages that you/your dependents are refusing and the reason for refusal.

BENEFICIARIES

Last name First MI	Relationship*	
		☐ Primary ☐ Secondary
		☐ Primary ☐ Secondary
		☐ Primary ☐ 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) If primary/secondary election is not noted, the beneficiary will be considered primary. 3) 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. 4) If your designation does not fit in the above arrangement, please contact Union Security Life Insurance Company of New York for the appropriate forms.

HEALTH QUESTIONS

Please answer the following questions. If you answer "YES" to any questions, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your eligible dependents.

Applicant: Height ________ Weight ________ **Spouse:** Height ________ Weight ________

	Yes	No
1. Have you or your dependents gained or lost 10 or more pounds during the past 12 months? If "Yes," how much ________	☐	☐
2. Have you [or your dependents within the past 5 years:		
a) Received or been advised to receive any medication, treatment, surgery, therapy, testing (except for HIV), 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?	☐	☐
b) Used any illegal drugs?	☐	☐
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?	☐	☐
4. Are you or your dependents pregnant?	☐	☐
5. Have you or your dependents used tobacco in any form in the past 12 months?	☐	☐
6. Have you or your dependents ever been treated or diagnosed as having: 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 (except HIV)? "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.	☐	☐

Name, address and telephone no. of personal physician ________________________________

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____

REMARKS-If you answered "YES" to any health question above, please provide details below.

(Attach additional sheets of paper if necessary.)

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

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

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 Life Insurance Company of New York. 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 Life Insurance Company of New York. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the 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 information and belief. 6) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured. 7) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, NOTICE CONCERNING CONSUMER REPORTS AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION. 8) Understand that I have the right to select any dental care provider of my choice. 9) 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.

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.

We may obtain an investigative consumer report, based on interviews with neighbors, acquaintances, and business contacts, concerning the character, general reputation, personal characteristics, and mode of living of any individuals involved in this application. Upon written request, the Company will: furnish detailed information as to the nature and scope of any such investigations, inform you if it was requested, and if it was, also furnish you with the name and address of the reporting agency to whom the request was made. You may inspect and receive a copy of such report by contacting the reporting agency.

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.

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

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, Medical Information Bureau or any other organization to give UNION SECURITY LIFE INSURANCE COMPANY OF NEW YORK or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, 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 LIFE INSURANCE COMPANY OF NEW YORK 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 years from the date shown below. I know that I have the right to revoke this authorization at any time. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

Pursuant to Section 403(d) and Regular 95 of the New York State Insurance Law, the following statement applies to our accident and health policies only: “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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

Employee’s signature ______________________________ Date ______________

Spouse’s signature (*if spousal coverage*) ______________________________ Date ______________

NOTICE REGARDING MEDICAL INFORMATION BUREAU

One of the prime objectives of Union Security Life Insurance Company of New York is to provide Insurance at low cost on an equitable basis to all policyholders. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes a fair share of the cost. In considering application for insurance, information from various sources must, therefore, be considered. These include the results of the proposed insured's physical examination, if required, and any reports we may receive from doctors and hospitals who have attended the proposed insured.

Information regarding factors affecting insurability will be treated as confidential. We may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If application is made to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with any information it may have in its file.

Upon receipt of a request, the Bureau will arrange disclosure of any information it may have in the file of the person making such a request. If the accuracy of the information in the Bureau's file is questioned, the Bureau may be requested to make a correction by following the same procedure as those set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The purpose of the Bureau is to protect the policyholders of its members from bearing the extra mortality cost created by those who would conceal facts relevant to their insurability. The Bureau is not a repository of medical reports from hospitals and physicians, and information in the Bureau file does not reveal whether applications for insurance are accepted, rated, or declined.

We may also release information in our file to our reinsurers and to other insurance companies to whom application is made for life or health insurance, or to whom a claim for benefits is submitted.

NOTICE CONCERNING CONSUMER REPORTS

An investigative consumer report may be obtained, based on interviews with neighbors, acquaintances, and business contacts, concerning the character, general reputation, personal characteristics, and mode or living of any individuals involved in this application. Upon written request, the Company will furnish detailed information as to the nature and scope of any such investigations, inform you if it was requested, and if it was, also furnish you with the name and address of the reporting agency to whom the request was made.

You may inspect and receive a copy of such investigative consumer report by contacting the reporting agency.

AUTHORIZATION TO FURNISH INFORMATION

By this form or a copy of it, I authorize any physician, practitioner, hospital, clinic, health care provider, health facility, medical or medically related facility, the Medical Information Bureau, employer, government or social agency, consumer reporting agency, or insurance company which possesses any records or knowledge as to diagnosis, treatment, or prognosis regarding me or my minor children to furnish such information to Union Security Life Insurance Company of New York, or its reinsurers upon presentation of this authorization or a photocopy thereof. This authorization is for the release of confidential HIV-related information in relation to diagnosis and/or treatment, as well as the release of information about drugs, alcoholism, and mental illness. This authorization does not apply to drug and alcohol records otherwise protected under applicable Federal regulations. This authorization will be valid for two years from the date shown previously. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.