

Union Security Life Insurance Company of New York

Employee Dental Application

G. O. no. _____

Group policy/participant no.		Account no.	Cert. no.	Employer	Employment location/phone no.			
Employee name Last First Initial		Full-time employ. date Mo. Day Yr.		Part-time employ. date Mo. Day Yr.		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee date of birth Month Day Year		No. hrs. per week _____		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 Other _____

Reason _____ Date _____

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

Employee: Dental

Dependent: Dental **Please mark X in box before the dependents to be covered:** Spouse Children

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).

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

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

***NOTE—** Coverages not specifically elected will not be made effective, even if not refused.

ELECTIONS NOT VALID WITHOUT SIGNATURE.

If coverage is refused, provide the reason for refusal. _____

IMPORTANT NOTICE TO APPLICANT — PLEASE READ CAREFULLY

My signature on this application certifies that I:

(1) Apply for the coverage designated for which I am eligible under my employer's plan with Union Security Life Insurance Company of New York. (2) Understand if coverage has been refused, I am not entitled to benefits under that coverage and that if I want to apply later, I understand 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) 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 my 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) 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.

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.

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

Signature _____ Date _____

Administrative Office: PO Box 2981 Clinton Iowa 52733-2981
T 888.901.6377

Plan Type	Coverage Effective Date Mo. Day Yr.		Plan I.D.	Schedule Class	Reduct. Cat.	Rate Class	Evid. Acpt.	Rate Slct.	Benefit Volume	Trans. Cd.	Frz. Cd.		
Evidence Type	# of lives	Serv. req.	Policy eff. date	Reviewed and Approved by _____ Date _____								HOME OFFICE USE	
Date Evid. Submitted		Mo.	Day	Year	Cert. Issued by _____ Date _____								
BENEFICIARY CHANGES - SETTLEMENT AGREEMENT													
REQUEST DATE	RECORDED BY	RECORDED DATE	REQUEST DATE	RECORDED BY	RECORDED DATE								