

Administrative Services Only Dental Employee Application



ASSURANT Employee Benefits

1st application Adding dependent Effective date _____

ALL AREAS MUST BE COMPLETED OR FORM WILL BE RETURNED; **PRINT LEGIBLY OR TYPE.**

EMPLOYEE INFORMATION

Name of employer	Plan no.	Division no.
------------------	----------	--------------

Name of employee (<i>last, first, middle initial</i>)	Part-time employment date	Full-time employment date
	Mo Day Yr	Mo Day Yr

Home address of employee (*street, city, state, zip code*)

Job title	Hours worked per week for this firm	Employee date of birth	Social Security no.	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
		Mo Day Yr			

List all dependents to be covered.

Last	First	Middle initial	Date of birth Mo/Day/Yr	Relationship to Employee

COVERAGES ELECTED

WAIVER SECTION

I am applying for:

- Employee Dental only
- Employee and Spouse Dental
- Employee and Child(ren) Dental
- Family Dental

I am *not* applying for the following coverage for which I am eligible:

- Employee Dental Reason _____
- Spouse Dental Reason _____
- Child(ren) Dental Reason _____

PLEASE READ CAREFULLY: I wish to apply for coverage under the dental plan administered by Union Security Insurance Company. I authorize my employer to deduct **premiums** from my earnings.

AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, insurance company, consumer reporting agency, employer, or any other organization to give Union Security Insurance Company or its reinsurers, ALL INFORMATION on my behalf including findings on dental care as they apply to me or any of my dependents who are to be covered.

I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original. This authorization will be valid for two and one half years (in Minnesota, 26 months) from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Signature of employee _____ Date _____

FOR COMPANY USE ONLY

Effective date _____ Date received _____

Union Security Insurance Company

Mail to: **Assurant Employee Benefits** PO Box 419423 Kansas City Missouri 64141-6423
T 800.757.9796 F 816.474.2422