UNION SECURITY INSURANCE COMPANY (the "Company")

Administrative Office: 300 Southborough Drive, Suite 200, South Portland, ME 04106

EMPLOYEE ENROLLMENT FORM FOR VOLUNTARY GROUP DISABILITY

This Area for Agent or Plan Administrator Use Only

Group Number:	Requested effective date of coverage: The first day of _____, _____ Month Year

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed by the Applicant. Failure to sign and date the application and to accurately complete the questions on this application may affect the existence or amount of coverage.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender ☐ M ☐ F	Social Security No.

Home Address Number/Street	City	State	Zip

Home Phone Number ( )	Employer Name	Your Work Location/Site

Date of Hire	Occupation	Annual Income $	Your scheduled work hours per week

Will the coverage applied for with this enrollment application:

a. *replace* any existing disability income coverage? ☐ Yes ☐ No

b. *be in addition to* any existing disability income coverage? ☐ Yes ☐ No

All applicants review the following guidelines and complete this section to request coverage.

- Amounts must be elected according to the Rate Schedule provided.
- Depending on the amount of coverage you elect, you may be required to complete the Health Questions.
- Consult your agent for details concerning maximum amounts of insurance and Evidence of Insurability requirements.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Monthly Benefit Amount	If (I) Or (D), My Prior Coverage Was	Monthly Premium / Rate
Short-Term Disability ☐ **Yes** ☐ **No** **Elimination Period** _____**Days** **Max. Period of Payment**_____				
Number of Salary Deductions/Year _____				

MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT:

I authorize the Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions and abide by any rules specified by the employer's benefit plan and/or by law. I apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. I understand that I must be actively at work on the effective date, or coverage will be deferred until I return to work and that dependent coverage (if applicable) will not become effective while the dependent is in a hospital or similar facility.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

The insurance applied for shall be in force as of the date described in the certificate provided the Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any such modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me and furthermore shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

All of the information on this application is complete, correct and true to the best of my knowledge and belief.

Dated at: _____ On: _____
City State Month Day Year

_____ _____
Signature of Employee Printed Name of Employee

Health Questions ***(For Employees Applying for Amounts of Insurance over the Guaranteed Issue Limit, Enrolling Late, Increasing Coverage, or Enrolling again after having Cancelled Coverage)***

Last Name	First Name	Middle Initial	Social Security No.

Please answer the following questions.
If you answer "YES" to any questions, please provide details in REMARKS below.

Height _____ Weight _____

1. Have you gained or lost 10 or more pounds during the past 12 months? ☐ Yes ☐ No
   If "YES", how much? _____
2. Have you within the past 5 years: ☐ Yes ☐ No
   a. Received or been advised to receive any medication, treatment, surgery, therapy, testing, 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? ☐ Yes ☐ No
3. In the past 5 years, have you 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? ☐ Yes ☐ No
4. Have you ever been diagnosed as having acquired immunodeficiency syndrome (AIDS)? ☐ Yes ☐ No
5. Are you pregnant? ☐ Yes ☐ No
6. Have you ever had, been medically diagnosed, treated or been advised to seek treatment for: ☐ Yes ☐ No
   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; or immune system disorder?

   "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 number of personal physician _____

_____

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

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

If Answering Health Questions, the Employee signature is required on page 4 of this form.

IMPORTANT NOTICE TO APPLICANTS ---- PLEASE READ CAREFULLY

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES (excluding psychotherapy notes)

(This authorization complies with the HIPAA Privacy Rule)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and the Company, *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, the Company, and the above-described representatives to evaluate my application for disability insurance and may be redisclosed to any organization or person employed by or representing Disability RMS or the Company solely to assist with this purpose. I give my permission to Disability RMS, the Company or its reinsurers to release any information to other life insurance companies as I may come in contact with. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization will remain in effect a maximum of six (6) months from the date of the signature below. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I or my authorized representatives have the right to revoke this authorization by notifying Disability RMS in writing. However, such revocation is not effective to the extent that Disability RMS and/or the Company have relied previously upon this authorization for the use or disclosure of my protected health information pursuant to this authorization, and as a result, may be the basis for denying insurance during a contestability period under applicable law. Failure to sign this authorization may impair Disability RMS' and/or the Company's ability to evaluate my application and as a result may be a basis for denying my application for disability insurance coverage.

*__California, Connecticut or Wisconsin__: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV). **Maine**: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS. **Vermont**: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC.

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. The Company or its reinsurers 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 you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone number: (866) 692-6901 (TTY 866-346-3642).

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, MO 64108-2670.

Unless specific state language is provided below, and except for Virginia, the following general fraud notice applies: *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.*

Florida and Oklahoma: *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.* **Ohio:** *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 is guilty of insurance fraud.* **New Jersey:** *Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.* **New York:** *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.*

Oregon*: Any person who knowingly, and with the 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 may be subject to prosecution for insurance fraud.*

I have read the NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES and the AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES and I have made a copy of my application for my records. To the best of my knowledge and belief, all statements made on this application are true and complete. I understand that my application for insurance will be accepted or declined on the basis of these statements.

Dated at: _____ On: _____/_____/_____
City State Month Day Year

_____ _____
Signature of Employee Printed Name of Employee