UNION SECURITY INSURANCE COMPANY
P.O. Box 981624, El Paso, TX 79998-1624
T 800.733.7879 F 888.208.2323

Employee Health Statement

Employee name *(last, first, initial)*			Employer	
Group policy/participant no.	Account no.	Cert. no.	Employee SSN	Employee birthdate

☐ New Enrollee ☐ Annual Enrollment ☐ Life Event-Type/Date ______________________________

Please answer the following questions. 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 in the past 12 months? If yes, how much _______________	☐	☐
2.	Have you or your dependents within the past 5 years, received any medication, treatment, surgery, therapy, testing by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium?	☐	☐
3.	In the past 5 years, have you or your dependents been treated for persistent cough, fatigue or swollen glands, pneumonia, chest pain, 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 been medically diagnosed or treated for: 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 or seizures?	☐	☐

"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Name, address and telephone number of personal physician ____

Employee's address ______________________ Daytime phone ( ) ______________________

If you answered "YES" toany questions, please provide details in REMARKS below.
And be sure to SIGN your form on the REVERSE side.

REMARKS

If you answered "Yes" to any medical questions above, please provide details below:

Question no.	First name	Description of illness injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending Physician or hospital (including zip)

Employee name		Employer
Group policy/participant no.	**Account no.**	**Cert. no.**

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.

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.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting purposes only, I give my permission to any physician or other medical practitioner, hospital, clinic, pharmacy, psychologist, insurance company, or consumer reporting agency or the Medical Information Bureau to give Union Security Insurance Company or its reinsurers any information regarding my medical or health history. I know that my authorized representative and I have a right to a copy of this authorization. I understand that a photocopy or facsimile of this authorization will be as valid as the original. This authorization will be valid for 30 months from the date shown below

MY SIGNATURE ON THIS APPLICATION INDICATES THAT I:

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (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. (3) Acknowledge that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured. (5) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION.

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 a state prison.

Employee's signature ______________________________ Date ______________

Spouse's signature (if spouse coverage elected) ______________________ Date ______________