Employee Health Statement for Voluntary and Worksite Coverage

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 _____

Answer the following questions based upon the coverage for which you are applying for you and your dependents. **For CANCER, answer questions 1 and 2 only. For CRITICAL ILLNESS or LIFE, answer questions 1 through 7. For SHORT AND LONG TERM DISABILITY, answer questions 1 through 8.**

Applicant Height:_____ Weight:_____ Spouse Height: _____ Weight: _____

	YES	NO
1. Have you or your dependents used tobacco, in any form in the past 12 months?	☐	☐
2. In the last 10 years, have you or your dependents been diagnosed, treated, or received advice from a licensed member of the medical profession to seek treatment for any tumor, malignancy or any type of internal cancer, melanoma, leukemia, lymphoma, sarcoma or Hodgkin's disease or been diagnosed with an elevated PSA, abnormal Pap or colposcopy? Have you had a hysterectomy or prostate removal?	☐	☐
3. In the past 5 years, have you or your dependents been hospitalized, undergone any inpatient or outpatient surgery or procedure or been advised by a licensed member of the medical profession to be hospitalized or have surgery?	☐	☐
4. In the past 12 months, have you or your dependents been prescribed or advised by a licensed member of the medical profession to take prescription medication?	☐	☐
5. Have you or your dependents ever been diagnosed, received treatment, or been advised by a licensed member of the medical profession to seek treatment for any mental, psychiatric, emotional or eating disorder, alcoholism, alcohol abuse, prescription or illegal drug abuse? Have you or your dependents ever been arrested for DUI, illegal drug possession or use?	☐	☐
6. Have you or your dependents ever been diagnosed, received treatment, or been advised by a licensed member of the medical profession to seek treatment for: **(circle all that apply and provide details below)** diabetes, heart or vascular disease, heart attack, blood disorder, stroke, high blood pressure, asthma, emphysema or other lung disorder, kidney disease, liver disease, gallstones, pancreas disorder, colitis, Crohn's disease, glaucoma, seizures, lupus or autoimmune disorder, multiple sclerosis, Parkinson's, Muscular dystrophy or any paralysis, arthritis, disorder of the back, neck, spine, or joint, including hip or knee?	☐	☐
7. Have you or your dependents ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐
8. Have you or your dependents ever been diagnosed with or treated for fibromyalgia, chronic fatigue, chronic pain, carpal tunnel, muscle or nerve disorder, eye or ear disorder, vertigo, bowel or bladder disorder?	☐	☐

***Note: "Disorder" is defined as a disease, illness or injury differing in any way from the usual or normal state or structure*.**

REMARKS

If you answered "Yes" to any medical questions above, please provide details below: **Sign and date the form on back.**

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

AUTHORIZATION TO RELEASE INFORMATION: To properly underwrite applications, determine eligibility for coverage and issue insurance policies on an equitable basis, we must obtain information about you. 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.

By signing below, I authorize any provider of medical services, physicians, or other medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager or any pharmacy related services entity, insurance company, employer, Medical Information Bureau, consumer reporting agency, or other individual or entity to give Union Security Insurance Company or its reinsurers any information regarding my medical or health history. Such information includes but is not limited to any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or pharmacy records.

I understand that I have the right to refuse to sign this authorization but if I refuse, Union Security Insurance Company may refuse to consider my application for enrollment. I understand that a photocopy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is voluntary and that I may revoke it at any time by writing Union Security Insurance Company, P.O. Box 981624, El Paso, TX 79998-1624 T 800.733.7879 F 888.208.2323 . Such revocation will not affect any action taken by Union Security Insurance Company prior to receipt of the revocation. If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.

The authorization is effective from the date signed below until the earliest of denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Union Security Insurance Company, but at no time longer than 24 months.

Federal law requires that we inform you that the information which we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. However, be assured that disclosure will be strictly limited to that which is reasonably necessary and we will comply with all federal and state privacy and security laws and regulations. You have the right to gain access to and request correction of information contained in our files.

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 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 satisfactory to Union Security Insurance Company. (3) Represent 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) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

This will certify that <u>I HAVE</u> read and understand the above important notice.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's signature _____ Date _____

Spouse's signature (if spouse coverage elected) _____ Date _____