

**ASSURANT EMPLOYEE BENEFITS  
UNION SECURITY INSURANCE COMPANY (the "Company")**

Administrative Office: One Riverfront Plaza, Westbrook, ME 04092-9700

**EMPLOYEE ENROLLMENT FORM FOR GROUP DISABILITY**

**This Area for Agent or Plan Administrator Use Only**

Group Number: <b>28694</b>	Requested effective date of coverage: The first day of _____, _____ Month Year
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**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 initiated 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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
			Age		

Home Address Number/Street	City	State	Zip
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Home Phone Number ( )	Employer Name <b>Irving ISD</b>	Your Work Location/Site
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Date of Hire	Occupation	Annual Income \$	Your scheduled work hours per week
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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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Elimination Period _____ Max. Period of Payment _____	N/A	N/A	N/A	N/A
Long-Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Elimination Period _____ Max. Period of Payment <u>5/SSNRA</u>	(Please complete this Section)			
Number of Salary Deductions/Year <u>12</u>				

**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: Irving Texas On: \_\_\_\_\_  
City State Month Day Year

\_\_\_\_\_  
Signature of Employee Printed Name of Employee