

**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>28844</b>	Requested effective date of coverage: The first day of _____, _____ Month Year
Agent Printed Name: <b>FALCO COMPANIES</b>	License Number: <b>A080562</b>

**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.
Home Address Number/Street		City	State	Zip	
Home Phone Number	Employer Name <b>MIAMI DADE COLLEGE</b>	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. <i>replace</i> any existing disability income coverage? b. <i>be in addition</i> to any existing disability income coverage?				<b>Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

**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.

**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.

**Florida residents:** 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.

Dated at: \_\_\_\_\_ On: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City State Month Day Year

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

\_\_\_\_\_  
Enroller/Agent **3012345**  
General Agent Number

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

<ul style="list-style-type: none"> <li>▪ LTD Benefit Amounts must be elected in \$100 increments.</li> <li>▪ For LTD coverage, all Employees are eligible to elect amounts of insurance up to the Maximum Benefit Amount without completing Health Questions. Employees may not elect amounts of insurance over the Maximum Benefit Amount.</li> </ul>				
Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Total Amount Of Coverage Applied For	If (I) Or (D), My Prior Coverage Was	Premium Amount <input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly
<b>Long-Term Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Elimination Period</b> _____ <b>Max. Period of Payment</b> _____		<b>Monthly:</b>		
<b>Number of Salary Deductions /Year</b> _____			<b>Total Premium:</b>	

**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.