

**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:	Requested effective date of coverage: The first day of _____, _____ Month Year
Agent Printed Name:	License Number:

**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.**

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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. <i>be in addition</i> to any existing disability income?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

<ul style="list-style-type: none"> <li>▪ Amounts must be elected according to the Rate Schedule provided.</li> <li>▪ Depending on the amount of coverage you elect, you may be required to complete the Health Questions.</li> <li>▪ Consult your agent for details concerning maximum amounts of insurance and Evidence of Insurability requirements.</li> </ul>				
Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Monthly Benefit Amount	If (I) Or (D), My Prior Coverage Was	Monthly Premium / Rate
Long-Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No				
Elimination Period _____				
Max. Period of Payment _____				
Number of Salary Deductions/Year _____				

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.

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 false, incomplete, or misleading information is guilty of a felony of the third degree.

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

\_\_\_\_\_  
Signature of Employee

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