*Fortis Benefits Insurance Company*
P.O. Box 2939
Clinton, IA 52733-2939

# EMPLOYEE APPLICATION

G.O. number _____

| Group Policy/Participant no. | Account no. | Cert. no. | Employer | Employment location/phone no. |
|---|---|---|---|---|
| 4022066 | | | | |

| Employee name: Last First Initial | Full-time employ. date Mo. Day Yr. | Part-time employ. date Mo. Day Yr. | Sex | Married | Children |
|---|---|---|---|---|---|
| | | | ☐ M ☐ F | ☐ Yes ☐ No | ☐ Yes ☐ No |

| Employee date of birth Month Day Year | Earnings ☐ Hourly No. hrs. per week ____ ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other ____ | Job title or position | State of residence | Employee Soc. Sec. no. |
|---|---|---|---|---|
| | | | | |

**Status:** *(If status area is not completed, we consider the employee to be active.)*
☐ Retired
☐ Continuation Reason _____ Date _____
☐ Leave of absence Reason _____ Date _____
☐ Other _____ Date _____

Please mark **X** in box before the coverages you are applying for if you are eligible for them under your employer's plan:

**Employee:** ☐ Life ☐ Accidental Death & Dismemberment ☐ Optional Additional Life Amount _____
☐ Short Term Disability ☒ Long Term Disability ☐ Dental

**Dependent:** ☐ Life ☐ Dental

***NOTE**—Coverages not specifically elected will not be made effective, even if not refused.

Were you covered under another dental plan within the last 31 days? ☐ No ☐ Yes
If "Yes", termination date ___/___/___

If dependent coverage is being applied for, please mark **X** in box before the dependents to be covered:
☐ Spouse ☐ Children

If spouse coverage is being applied for, complete the following:

Spouse's date of birth Month Day Year | Spouse's Social Security no. | Spouse's employer | Spouse's current dental insurance carrier

Write in the names and dates of birth of children to be covered (*Subject to plan provisions*):

Write in any coverages that you/your dependents are refusing and the reason for refusal:

## BENEFICIARIES

| Last name First MI | Relationship* | Primary ☐ Secondary ☐ |
|---|---|---|
| | | Primary ☐ Secondary ☐ |
| | | Primary ☐ Secondary ☐ |

*If beneficiary is not related to you, please provide Date of Birth, Social Security number, and full address.
(1) Give FULL names and relationships of each beneficiary. (2) If primary/secondary election is not noted, the beneficiary will be considered primary. (3) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. (4) If your designation does not fit in the above arrangement, please contact Fortis Benefits for the appropriate forms.

## IMPORTANT NOTICE TO APPLICANT—PLEASE READ CAREFULLY

***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 Fortis Benefits 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 Fortis Benefits Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the Late Entrant Limitation Period specified in the policy. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured. (7) Understand that I have the right to select any dental care provider of my choice. (8) Understand that the dental plan includes a pre-authorization provision, that will advise me in advance of the benefits I may be eligible for if the procedure is performed.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**This will certify that I HAVE read and understand the above important notice.**

Signature _____ Date _____

| Plan type | Coverage effective date Mo. Day Yr. | Plan ID | Schedule class | Reduct. cat. | Rate class | Rate slct. | Benefit volume | Trans. code | Frz. code |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

### HOME OFFICE USE

| Evidence type | No. of lives | Serv. req. | Policy eff. date | Reviewed and approved by _____ Date _____ |
|---|---|---|---|---|
| Date evid. submitted Mo. Day Year | | | | Cert. issued by _____ Date _____ |

### BENEFICIARY CHANGES • SETTLEMENT AGREEMENT

| Request date | Recorded by | Recorded date | Request date | Recorded by | Recorded date |
|---|---|---|---|---|---|
| | | | | | |