_ **Freedom Preferred**

Assurant Employee Benefits

_ **Freedom Basic**

Group Dental Insurance Enrollment Card

Check one – Employer Use
☐ **Initial Employee:**
☐ **Transfer from Prior Dental**
☐ **Non-Transfer**
☐ **New Employee**
Date of Hire _____
☐ **Change**
☐ **Open Enrollment**

(Please print clearly.)

Employer Name	Effective Date:	Policy Number: Division:

Employee First Name	MI	Last Name

Address	City	State	Zip

Social Security No.	Birthdate	Phone	Sex ☐ M ☐ F

DENTAL COVERAGE

I APPLY FOR:
☐ Employee only
☐ Employee and eligible dependents
Check One (if applicable): ☐ Hi Option ☐ Lo Option

☐ **I DECLINE COVERAGE FOR:**
☐ Employee
☐ Spouse
☐ Child(ren)

Do you have eligible dependents? ☐ Yes ☐ No If "Yes," complete below to enroll them.	Relation	Sex	Birthdate Mo	Day	Year	For children age 19 or older, indicate if a full-time student. Yes	No
Spouse							
Child(ren)							

☐ List additional Children on reverse side and check box.

- If the address of any child is different than the employee's address, please show that **child's name and address** below.
  _____
- Name of the custodial parent or organization requesting coverage for such dependent child
  _____
- Name of the custodial parent or organization responsible for payment of premium for such dependent child
  _____
- If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Union Security Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Date _____ Signature _____