Employee Application for Hospital Confinement Indemnity "Gap" Insurance

ASSURANT Employee Benefits®

Please print clearly in blue or black ink.

Issue

Policy Number: MG-111-

APPLICANT INFORMATION:

Name (last, first, middle)				Sex ☐ M ☐ F
Age	Date of Birth (mm/dd/yy)	Social Security Number	Home Phone #	Work Phone #
Street Address			E-Mail	
City		State	Zip Code	
Employer		Occupation		Date of Hire
Coverage Selected:	☐ Employee ☐ Employee & Child(ren)		☐ Employee & Spouse ☐ Employee & Family	
Monthly Premium: $		Requested Effective Date of Coverage/Change:		

DEPENDENT INFORMATION

	Name (last, first, middle)	Birth Date	Sex	Social Security #
Spouse				
Child				
Child				
Child				
(Use reverse side of form if additional space is needed)				

I hereby: ☐ **ENROLL**, or ☐ **CHANGE** as indicated above, for this group insurance coverage for which I am eligible. I understand and acknowledge: That no coverage will take effect for any person to be covered who is not also covered by a Major Medical/Comprehensive Policy including Coinsurance and Deductible, in force at the time of my proposed Effective Date for this coverage.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Applicant's Signature ► _____ Date _____

Parent or Legal Guardian if the Applicant is Under Age 18

Agent's Signature ► _____
(where applicable by law)

A-01026CA M-9054

Assurant Employee Benefits is the brand name for Group Hospital Confinement Indemnity insurance underwritten by Fidelity Security Life Insurance Company.

Mail to: Assurant Employee Benefits Attn: Worksite, P.O. BOX 419569, Kansas City, MO 64141-6596

03/2010