LIBERTY UNION LIFE ASSURANCE COMPANY 560 KIRTS BLVD SUITE 125 TROY MI 48084

New Employee Enrollment	□ Open Enrollment
Change for Existing Employee	(Complete Change Request Section)
PLAN/GROUP	

## **EMPLOYEE APPLICATION**

MUST BE COMPLETED BY THE EMPLOYEE, SPOUSE OR DEPENDENT CHILDREN AGE 18 OR OLDER
(Not to be completed by the Agent, Employer or any other person not named as an applicant on this form)

EMPLOYER NORMATION (TO BE COMPLETED IN ALL SITUATIONS)  EMPLOYER ADDRESS CITY STATE ZIP  EMPLOYER (Full Time)	(Not to be c	ompleted by the	ne Age	nt, Employer or	any	y other p	erson	not i	named as	an ap	pplicant on	this form	1)	
DATE OF HIRE (Full Time)  AVERAGE HOURS WORKED PER WEEK   EMPLOYEE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)  LAST NAME  FIRST NAME  FIRST NAME  ADDRESS  CITY  FIRST NAME  CELL PHONE (C)  CELL PHONE (C)  CELL PHONE (C)  DATE OF BIRTH (MDDY)  DEPENDENT INFORMATION (TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED)  LAST NAME  FIRST NAME  INITIAL  RELATIONSHIP  BENEFICIARY  BENEFICIARY  OTHER INSURANCE (TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED)  LAST NAME  FIRST NAME  INITIAL  RELATIONSHIP  SEX  BATE OF HEIGHT  WEIGHT  SOCIAL SECURITY NUMBER  RELATIONSHIP  BENEFICIARY  OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid?  Type: Medical Dental Pediatric Dental Pe		EMPLOY	ER IN	FORMATION (T	ОВ	E COMP	LETED	IN A	ALL SITUA	AOITA	IS)			
DATE OF HIRE (Full Time)   AVERAGE HOURS WORKED   PER WEEK   PER	EMPLOYER NAME		E	T T					CIT	Y				
PER WEEK   S PER	EMPLOYER LOCATION		C	OCCUPATION										
EMPLOYEE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)  LAST NAME  FIRST NAME  FIRST NAME  MIDDLE INITIAL  ADDRESS  CITY  STATE  ZIP  HOME PHONE  ( )  BEMAIL ADDRESS  CITY  SOCIAL SECURITY NUMBER  RELATIONSHIP  BENEFICIARY  BENEFICIARY  BENEFICIARY  DEPENDENT INFORMATION (TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED)  LAST NAME  FIRST NAME  INITIAL  RELATIONSHIP  SPOUSE  SPOUSE  BENEFICIARY  OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? "YES" NO  If YES.  Person(s) Covered  Person(s) Covered  Person(s) Covered  Person(s) Covered  Person(s) Covered  DEPENDENT LIFE: # OF UNITS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DATE OF CHANGE: / / /  PRIOR COVERAGE  CHANGE REQUEST (please select appropriate change and complete the new information on this application)  DATE OF CHANGE: / / /  PRIOR COVERAGE  COVERAGE INFORMATION TO REMOVE DEPENDENTS (list names)  DATE OF CHANGE: / / /  PRIOR COVERAGE  COVERAGE INFORMATION TO REMOVE DEPENDENTS (list names)  DATE OF COVERAGE  COVERAGE INFORMATION TO REMOVE DEPENDENTS (list names)  DATE OF COVERAGE  COVERAGE INFORMATION TO REMOVE DEPENDENTS (list names)  DATE OF COVERAGE  COVERAGE INFORMATION TO REMOVE DEPENDENTS (li	DATE OF HIRE (Full Time)				RS V	VORKED			BAS					
ADDRESS  CITY  STATE  ZIP  HOME PHONE CELL PHONE CELL PHONE EMAIL ADDRESS  DATE OF BIRTH (MD/Y)  BENEFICIARY  BENEFICIARY  DEPENDENT INFORMATION (TO BE COMPLETED DOLLY IF DEPENDENTS ARE TO BE COVERED)  LAST NAME FIRST NAME INITIAL RELATIONSHIP SEX DOLLAR SEQUENTY NUMBER  SPOUSE  OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? LYES LNO ITYES:  Person(s) Covered Plan or Carrier Name  COVERAGE INFORMATION (TO BE COMPLETED IN ALL STUDIATIONS)  LIFE INSURANCE: MINIMUM AMOUNT OR SERVICE SPOUSE Spouse Employee & Children Family NONE  DEPENDENT LIFE: # OF UNITS  MEDICAL Employee Only Employee Spouse Employee & Children Family NONE  DEPENDENT LIFE: # OF UNITS  MEDICAL Employee Only Employee A Spouse Employee & Children Family NONE  DEPENDENT LIFE: # OF UNITS  MEDICAL Employee Only Employee & Spouse Employee & Children Family NONE  DEPENDENT LIFE: # OF UNITS  MEDICAL Employee Only Employee A Spouse Employee & Children Family NONE  DEPENDENT LIFE: # OF UNITS  MEDICAL Employee Only Employee & Spouse Employee & Children Family NONE  DEPENDENT LIFE: # OF UNITS  MEDICAL Employee Only Employee A Spouse Employee & Children Family NONE  DEPENDENTS CHANGE INFORMATION TO RESPROYEE ADDRESS EMPLOYEE ADDRESS EMPLOYEE ADDRESS FROM COMPLETED TO MAKE CHANGE (provious name)  CHANGE REQUEST (please select appropriate change and complete the new information on this application)  CHANGE REQUEST (please select appropriate change and complete the new information on this application)  DATE OF CHANGE: JAME OF COVERAGE EMPLOYEE ADDRESS EMPLOYEE ADDRESS FROM COVERAGE FROM TOWN DATE of CO		FMPI O			O B	F COMP	FTFD	IN A	ALL SITUA	AOIT	,			
ADDRESS  CITY  STATE  ZIP  HOME PHONE ( )  CELL PHONE ( )  CEL	LAST NAME	Liiii Lo		,		L OOM		11 4 7			<u> </u>		DIVORCED	
DATE OF BIRTH (MD/Y)  BENEFICIARY  DEPENDENT INFORMATION (TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED)  LAST NAME FIRST NAME INITIAL RELATIONSHIP SEX DATE OF HEIGHT WEIGHT SOCIAL SECURITY NUMBER  OTHER INSURANCE: (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? "YES INO II YES: Person(s) Covered Plan or Carrier Name  COVERAGE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)  LIFE INSURANCE: MINIMUM MOUNT OR SOCIAL SECURITY (MANUMENT)  LIFE INSURANCE: MINIMUM MOUNT OR SOCIAL SECURITY (MANUMENT)  DEPENDENT LIFE: # OF UNITS SOCIAL SECURITY (MF)  DEPENDENT LI	EAST NAME	□ MARRIED												
DATE OF BIRTH (MD/Y)  BENEFICIARY  DEPENDENT INFORMATION (TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED)  LAST NAME  FIRST NAME  INITIAL  RELATIONSHIP  SEX DATE OF HEIGHT  WEIGHT  SOCIAL SECURITY NUMBER  RELATIONSHIP  BIRTH  WEIGHT  SOCIAL SECURITY NUMBER  SOCIAL SECURITY NUMBER  SOCIAL SECURITY NUMBER  OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? TYES NO  If YES:  Person(s) Covered   Type:   Medical   Dental   Pediatric Dental   Plan or Carrier Name   D#  COVERAGE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)    LIFE INSURANCE:   MINIMUM AMOUNT OR   S   S   S   DEPENDENT LIFE:   OF UNITS   Employee & Spouse   Employee & Children   Family   NONE   DEPENDENT LIFE:   OF UNITS   Employee & Spouse   Employee & Children   Family   NONE   DEPENDENT   Employee Only   Employee & Spouse   Employee & Children   Family   NONE   DEPENDENTS   CHANGE REQUEST (please select appropriate change and complete the new information on this application)  BENEFICIARY CHANGE   NEW EMPLOYEE ADDRESS   EMPLOYEE NAME CHANGE (previous name)   DATE MARRIED   DATE MARRIED   DATE MARRIED   DATE OF CHANGE:   J J J PRIOR COVERAGE   DATE MARRIED   DATE OF CHANGE:   J J J PRIOR COVERAGE   DATE MARRIED   DATE OF COVERAGE   Types of Coverage	ADDRESS		C	CITY							STATE		ZIP	
BENEFICIARY    DEPENDENT INFORMATION   TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED	HOME PHONE ( )		CELL (	ELL PHONE EMAIL ADDRESS										
LAST NAME   FIRST NAME   INITIAL   RELATIONSHIP   SEX   (MF)   BIRTH   WEIGHT   SOCIAL SECURITY NUMBER	_	SEX (M/F)	F	HEIGHT WEIGHT SOCIAL SECURITY NUMBER										
LAST NAME FIRST NAME INITIAL RELATIONSHIP SEX (MF) BIRTH HEIGHT WEIGHT SOCIAL SECURITY NUMBER  SPOUSE  SPOUSE  OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? SYES NO If YES.  Person(s) Covered Prior Name  COVERAGE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)  LIFE INSURANCE: MINIMUM AMOUNT OR SUPPLEMENTAL LIFE SUPPLEMENTA	BENEFICIARY RELATIONSHIP													
SPOUSE  OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? TYES NO If YES:  Person(s) Covered Type: Medical Dental Pediatric Dental Plan or Carrier Name  COVERAGE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)  LIFE INSURANCE: MINIMUM AMOUNT OR S SUPPLEMENTAL LIFE WAIVER  MEDICAL Employee Only Employee & Spouse Employee & Children Family NONE PRESCRIPTION Employee Only Employee & Spouse Employee & Children Family NONE Employee Only Employee & Spouse Employee & Children Family NONE Employee Only Employee & Spouse Employee & Children Family NONE Employee Only Employee & Spouse Employee & Children Family NONE Employee Only Employee & Spouse Employee & Children Family NONE Employee Only Employee & Spouse Employee & Children Family NONE Employee ADD DENTAL Employee Only Employee & Spouse Employee & Children Family NONE EMPLOYEE ADDRESS EMPLOYEE NAME CHANGE (previous name)  BENEFICIARY CHANGE NEW EMPLOYEE ADDRESS EMPLOYEE NAME CHANGE (previous name)  DATE MARRIED DATE DIVORCED DATE DIVORCED DATE DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE IN LIFE AMOUNT REMOVED DEPENDENTS (list names)  DATE OF CHANGE REMOVED DEPENDENTS (list names)	DEPENI	DENT INFORM	ATION	(TO BE COMPI	LETI	ED ONLY	IF DE	PEN	IDENTS AI	RE TO	BE COVE	RED)		
OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)  1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? "YES	LAST NAME FIRS	T NAME IN	ITIAL	RELATIONSH	IP				HEIG	HT	WEIGHT			Υ
1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid?     YES	SPOUSE													
1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid?     YES														
1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid?     YES														
1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid?     YES														
1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid?     YES														_
or Medicaid?   YES   NO   If YES:   Person(s) Covered   Type:   Medical   Dental   Pediatric Dental   Pelatric Dental	OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)													
Plan or Carrier Name	or Medicaid? □YES □NO													
LIFE INSURANCE:   MINIMUM AMOUNT OR   \$														
DEPENDENT LIFE: # OF UNITS   Employee Only   Employee & Spouse   Employee & Children   Family   NONE   NONE   PRESCRIPTION   Employee Only   Employee & Spouse   Employee & Children   Family   NONE   NONE   DENTAL   Employee Only   Employee & Spouse   Employee & Children   Family   NONE   NONE   DENTAL   Employee Only   Employee & Spouse   Employee & Children   Family   NONE   NONE   DENTAL   NEW EMPLOYEE ADDRESS   EMPLOYEE NAME CHANGE (previous name)   NONE   DATE MARRIED   DATE DIVORCED   DATE DIVORCED   DATE OF CHANGE:   DATE OF CHANGE:   J	COVERAGE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)													
MEDICAL	☐ LIFE INSURANCE: ☐ MII	NIMUM AMOUN	NT OR	□ <b>\$</b>					SUPPLEM	/ENT	AL LIFE \$_			
□ PRESCRIPTION □ Employee Only □ Employee & Spouse □ Employee & Children □ Family □ NONE □ DENTAL □ Employee Only □ Employee & Spouse □ Employee & Children □ Family □ NONE  CHANGE REQUEST (please select appropriate change and complete the new information on this application)  □ BENEFICIARY CHANGE □ NEW EMPLOYEE ADDRESS □ EMPLOYEE NAME CHANGE (previous name) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	☐ DEPENDENT LIFE: # OF	UNITS										<u>\</u>	<b>NAIVER</b>	
DENTAL	□ MEDICAL □ Employee Only □ Employee & Spouse □ Employee & Children □ Family □ NONE													
CHANGE REQUEST (please select appropriate change and complete the new information on this application)  BENEFICIARY CHANGE  NEW EMPLOYEE ADDRESS  EMPLOYEE NAME CHANGE (previous name)  REMOVE DEPENDENTS (list names)  DATE MARRIED  DATE DIVORCED  DATE OF CHANGE:  DATE OF CHANGE:  PRIOR COVERAGE  Complete to determine appropriate credit. Certificate of creditable coverage from your prior carrier should be attached. Prior Coverage Start Date  Covered Individuals	□ PRESCRIPTION □ Employee Only □ Employee & Spouse □ Employee & Children □ Family □ NONE													
BENEFICIARY CHANGE   NEW EMPLOYEE ADDRESS   EMPLOYEE NAME CHANGE (previous name)														
ADD DEPENDENTS CHANGE IN LIFE AMOUNT REMOVE DEPENDENTS (list names )	CHANGE F	REQUEST (plea	ase sel	ect appropriate o	han	ge and co	omplete	e the	new inforr	mation	n on this app	olication)		
DATE MARRIED DATE DIVORCED  OTHER (explain) DATE OF CHANGE: /  PRIOR COVERAGE  Complete to determine appropriate credit. Prior Coverage Start Date End Date Types of Coverage  Covered Individuals	□ BENEFICIARY CHANGE □ NEW EMPLOYEE ADDRESS □ EMPLOYEE NAME CHANGE (previous name)							_						
DATE MARRIED DATE DIVORCED  OTHER (explain) DATE OF CHANGE: /  PRIOR COVERAGE  Complete to determine appropriate credit. Prior Coverage Start Date End Date Types of Coverage  Covered Individuals	□ ADD DEPENDENTS □ CHANGE IN LIFE AMOUNT □ REMOVE DEPENDENTS (list names )													
PRIOR COVERAGE  Complete to determine appropriate credit. Prior Coverage Start Date End Date Types of Coverage	DATE MARRIED DATE DIVORCED													
Complete to determine appropriate credit.  Prior Coverage Start Date End Date Types of Coverage Types														
Prior Coverage Start Date End Date Types of Coverage Covered Individuals														
Prior Plan or Carrier Name Reason for ending prior coverage	Prior Coverage Start Date End Date Types of Coverage						∍d. –							
	Prior Plan or Carrier Name	 e				F	Reason	for	endina pr	ior co	overage			_

I (the Employee) completed the following information as it pertains to me and that of my dependents. If I am not applying for dependent coverage, then the answers relate to me only. If I am applying for dependent coverage, I verify the signatures below are that of my spouse and/or dependent children age 18 or older. NOTE: ANY PERSON WHO SUBMITS AN APPLICATION, FILES A CLAIM WITH INTENT TO DEFRAUD, OR HELPS COMMIT FRAUD IS GUILTY OF A CRIME THAT MAY BE PUNISHABLE BY LAW YES **YES** NO TO BE COMPLETED BY APPLICANT(S) ONLY Alcohol, chemical or substance abuse? Liver cirrhosis, pancreatitis. k: disorder, 1: Are you currently actively employed on a full-time basis? hepatitis? П П Stroke, paralysis, epilepsy? m: Sleep disorder/sleep apnea? Are you or any dependent, whether or not named on this Cancer, tumor? application, now pregnant; Birth defects? Been treated/tested for infertility, premature delivery, Neurological condition or multiple sclerosis? miscarriage, c-section or any other complications of Systemic lupus? q: pregnancy? Deviated septum or breathing disorder? Do you anticipate adding any dependent(s) to your coverage within the next 12 months? 3: Are you or any dependent now disabled or confined to a s: Glaucoma, cataracts, or diseases of the eye? Medical Facility? Otitis media, ear or hearing disorder? П Skin disease or skin disorder? П П Have you or any dependent incurred medical expenses Have you or any dependent smoked cigarettes more than \$5000 in the previous 24 months? in the last 12 months? Within the past 5 years, have you or any dependent had Are you or any dependent presently ill, taking medication, receiving treatment, or been any indication, diagnosis, consultation, treatment, taken any medication or received counseling for: advised of a condition that will require treatment or surgery in the next 12 months? Stomach, gallbladder, Crohn's disease, intestinal or Have you or any dependent had medical care colon disorder? or treatment by a medical professional for П Bladder, kidney disorder, protein or blood in urine? AIDS or any AIDS related complex, for any Male/female organ disorders infertility, sexually immune system disorder or tested positive for transmitted disease? HIV? Heart, circulatory disorder, varicose veins, high blood pressure? П Emphysema, asthma or other disease of the lungs or Have you or any dependent, for any reason respiratory system? NOT stated above, during the past 5 years: Thyroid disorder or lymph node enlargement? Been hospitalized or advised be Diabetes, blood or blood sugar disorder? hospitalized? П П Nervous, mental or emotional disorder? b: Had surgery or advised to have surgery? c: Had any injury, illness, medical attention, medical advice or treatment? Arthritis, back or joint disorder, received chiropractic care? П П П П DETAILS TO "YES" ANSWERS (If more space is needed attach an additional sheet of paper, dated and signed) Question NAME CONDITION TREATMENT, MEDICATION, DOSAGE & **DATES** PROVIDE NAME, ADDRESS & Number PHONE OF ALL PHYSICIANS FOR **DIAGNOSIS RECOVERY STATUS TREATED** YOURSELF AND FAMILY - USE SEPARATE SHEET, IF NEEDED. APPLICANT VERIFICATION OF ENROLLMENT STATEMENTS I state the above answers are true and complete. I understand that intentional failure to disclose information that is reasonably known by me or my dependents will result in a rescission (termination) of coverage. The Administrator has the right to rescind due to intentional material misrepresentation during enrollment. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION** I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or any entities covered under the HIPAA Privacy Rule and their agents and employees to disclose my personal health information to the Administrator or their authorized representative. This includes information about the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This is also valid for my dependents. I understand this authorization will be used by the TPA/Administrator for the purpose of underwriting my application for coverage, eligibility, rating and enrollment decisions regarding the coverage I am applying for. I understand that any authorized representative or I may receive a copy of this authorization upon request. This authorization is valid from the date signed and until the date any approved coverage is terminated unless revoked by me in writing to the Administrator which I may do at any time. Any revocation will not affect any prior use of this authorization by the

Administrator. I understand information obtained with my authorization may be re-disclosed by the Administrator as permitted or required by Law and no longer protected by the federal privacy law. I have had the opportunity to read and consider the contents of this authorization and confirm that the contents are consistent with my direction.

EMPLOTEE SIGNATURE	
SPOUSE SIGNATURE	DATE
DEPENDENT SIGNATURE (AGE 18 OR OVER)	DATE
DEPENDENT SIGNATURE (AGE 18 OR OVER)	DATE