

REGARDING: DOC Enrollment

FROM: Payroll and Benefits

SUBJECT: **Assurant Insurance Information**

Please note the current premiums for coverage are as follows:

<u>Optional Type and Amount</u>	<u>Employee Charge</u>
\$10,000 Mandatory on-the-job coverage	\$ 0.00
\$10,000 Member only –full life coverage	\$ 4.50
\$10,000 Plus dependent- full life coverage	\$ 5.50
\$20,000 Member only-full life coverage	\$ 9.45
\$20,000 Plus dependent-full life coverage	\$10.45
\$30,000 Member only-full life coverage	\$14.40
\$30,000 Plus dependent-full life coverage	\$15.40

(Includes \$0.15 charge for administration)

Assurant Employee Benefits PO Box 419262, Kansas City, Missouri 64141-6262		Application for Group Insurance – Oregon Firefighters, Volunteer Firefighters and Police Officers	
IMPORTANT All Items must be completed. Please type or print with pen. Group Policy #4005790 Acct# 001			
Name of applicant (last, first, MI)		Sex M F	Social Security Number(optional) Date of Birth Mo Day Year
Name of Public Employer OREGON DEPARTMENT OF CORRECTIONS	Duties as Public Employee Police Officer		Hire/Volunteer Date Mo Day Year
Type and amount of insurance (check one) <input type="checkbox"/> \$10,000 Mandatory Occupational Coverage <input type="checkbox"/> \$10,000 Full Group Life <input type="checkbox"/> \$20,000 Full Group Life <input type="checkbox"/> \$30,000 Full Group Life		Dependent Insurance I wish to insure my dependents: <input type="checkbox"/> Yes <input type="checkbox"/> No The term "dependent" means the applicant's spouse and any unmarried child 14 days but less than 23 years of age. No person who is eligible for benefits as a public employee shall be considered a dependent.	
Name of Beneficiary (last, first, middle initial)		Relationship of beneficiary to applicant	

I hereby apply for the Group Insurance indicated above for which I am now or may later become eligible under the Group Policy issued by Union Security Insurance Company covering the Public Employer specified above. I agree to make the required contributions, if any, toward the cost of my insurance and authorize payroll deductions for that purpose. I understand and agree that the insurance issued on the basis of this application shall become effective only in accordance with the terms of the Group Policy.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Date _____ Signature of Applicant _____

Received by Payroll: _____ Coverage start date: _____ Employee Received certificate and booklet: _____
--