Evidence of Insurability Instructions

You have elected Life and/or Disability coverage through your employer that requires the completion of an Evidence of Insurability (EOI) application. Read the instructions below before completing.

You may submit this application electronically (via Adobe Sign), or via paper format. Employees and spouses need to apply on separate applications.

To complete your application successfully, you should have the following information available to you:

- **Employer's Name and Group # of the employee;** These fields must be completed. If you do not know your employer's group #, please contact your Benefits Administrator to obtain.
- **If you are a spouse.** Also include Employee name, social security, date of birth, date of hire, income, and coverage amounts.
- **Medical Conditions.** List of your medical conditions to include dates and treatments.
- **Medications**. List of your medications and dosage.
- **Medical History.** Names, address, phone numbers and dates of doctors, practitioners, or counselors you have seen within the past 5 years for anything other than a minor illness.
- **Physician Details**. Contact information of the doctor you see for routine physicals and exams.

Products Being Underwritten
This section must be completed to process the request for coverage. Disregard any coverage(s) that you are not applying for at this time, as they are not applicable. Contact your Benefits Administrator prior to submitting your application with any questions regarding the type(s) and amount(s) of coverage you have and are requesting at this time.

- **Current Coverage with Employer**. The amount you currently have with your employer, including Guaranteed Issue Amounts. If you do not coverage currently with your Employer, enter "0".
- **Additional Amount Requested**. Enter the additional benefit amount you are applying for.
- **Total Coverage**. Enter the total of current coverage **plus** the additional amount being requested.

Privacy Practices Notice should be reviewed and kept for your records.

Submitting the Application, Signature and Date

1. **If you apply electronically via Adobe Sign**, complete all the information requested, electronically sign, date and submit the application. Upon completion, an email will be sent to you to validate, then a copy of your application will be emailed to you. Save a copy of your application for your records. Incomplete applications will delay your request for coverage.
2. **If you apply via paper format**, follow the Adobe Sign instructions on how to print a copy of the application, complete the application, **print**, **sign in black ink**, date, and email or fax to UnitedHealthcare's Group Medical Underwriting Services. Electronic signature is not acceptable on this format. Incomplete applications, missing ink signature, or missing dates will be returned for you to complete and will delay your request for coverage. Keep a copy for your records.

   Group Medical Underwriting Services
   Fax: 855-290-5224 **Email**: EOI_Underwriting@uhc.com

All Fields With An * Must Be Completed						
***Reason for application**: ◯ Initial Enrollment (including new hire/rehire) ◯ Late Entrant ◯ Open Enrollment ◯ Increase ◯ Applying for Increase over Guarantee Issue Amount ◯ Qualifying Life event (Reason) Event date ◯ Other (Reason) Event date						
*Employer Name						
Group #	Location/Division/Sub Group #			Class #		
Employee Date of Hire or Rehire MM/DD/YYYY			Employee Income ◯ Salaried: Annual Base Salary ◯ Hourly: Rate $ # of Hours per week			

Persons Applying for Coverage **Contact Your Benefit Administrator/ Employer for Confirmation of Coverage**						
	Employee			**Spouse** Includes Domestic Partner / Civil Union as determined by state law or Employer		
***First and Last Name**						
***Social Security #**						
***Height & Weight**	***Ft**	***In**	***Lbs**	***Ft**	***In**	***Lbs**
***Gender** (check one)	☐ Male	☐Female	☐ Non-Binary	☐ Male	☐Female	☐ Non-Binary
***Physical Address:**				☐ check if same as Employee		
***Street Address**						
***City, State, Zip Code**						
Mailing Address (if different than Physical Address)				☐ check if same as Employee		
Street Address						
City, State, Zip Code						
***Personal Email Address**						
***Contact Number**						
***Date of Birth MM/DD/YYYY**						
***Place of Birth** (U.S. State or Country)						

Coverage being requested	**Employee**			**Spouse**		
	Current coverage with Employer (include Guarantee Issue, if eligible. If none enter $0)	Additional Amount Requested	Total Coverage Current + Additional	Current coverage with Employer (include Guarantee Issue, if eligible. If none enter $0)	Additional Amount Requested	Total Coverage Current + Additional
Basic Life	$	$	$	$	$	$
Supplemental Life	$	$	$	$	$	$
Short Term Disability (list $ amount or %)	$ %	$ %	$ %			
Long Term Disability (list $ amount or %)	$ %	$ %	$ %			

Medical Questions Section: Employee and Spouse Applying for Coverage Must Complete This Section.

The following questions are to the best of the knowledge and belief of the person applying for coverage.	**Employee**		**Spouse**	
	Yes	No	Yes	No
1. Within the past 10 years, has any person proposed for coverage tested positive for exposure to the Human Immunodeficiency Virus (HIV), or been diagnosed or treated by a medical professional for Acquired immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	◯	◯		
2. Within the past 10 years, has any person proposed for coverage been medically treated or diagnosed, by a medical professional, with a stroke; more than one TIA; cardiac stent placement; pacemaker implant; congestive heart failure; cirrhosis of the liver; chronic hepatitis B or C; heart attack; cardiac bypass surgery; multiple sclerosis; bipolar disorder; or schizophrenia?	◯	◯		
3. Has any person proposed for coverage been medically treated or diagnosed, by a medical professional, with diabetes prior to age 30; diagnosed with diabetes in addition to coronary artery disease, eye, kidney or nerve issues; insulin dependent diabetes, or in the past year had an A1c level of 8.0 or higher?	◯	◯		
4. Within the past 2 years, has any person proposed for coverage been medically treated or diagnosed, by a medical professional, with high blood pressure (hypertension) or atrial fibrillation requiring an emergency room visit; or taking 3 or more high blood pressure medications concurrently?	◯	◯		
5. Other than as stated in questions 2-4, within the past 10 years, has any person proposed for coverage been medically treated or diagnosed, by a medical professional, with diabetes or any other endocrine disorder; cancer; high blood pressure (hypertension); heart or circulatory disorder; coronary artery disease; COPD; emphysema; asthma; lung or other respiratory disorder; digestive disorder; gastrointestinal disorder; pregnancy; complications of pregnancy; PCOS or any other reproductive condition; rheumatoid or orthopedic disorder; hematologic disorder; infectious disease or virus; TIA or any other neurological disorder; disorder of the immune system; liver; kidney or other nephrology or urology disorder; nervous or psychiatric disorder; alcoholism; narcotic; opioid or other drug addiction or any other conditions that are not listed above, or been convicted of a felony?	◯	◯		

***Provide Name and Address of Physician Seen for Routine Exams**		
	Employee	**Spouse**
*Physician's Name		
*Street Address		
*City, State, Zip Code		
*Phone Number		
*Date Last Seen, Reason for Visit and Results		

Medical Questions Section: Employee and Spouse Applying for Coverage Must Complete This Section.

The following questions are to the best of the knowledge and belief of the person applying for coverage.

6. Within the past 10 years has any person proposed for coverage or had a medical professional diagnose or treat:	**Employee**		**Spouse**	
	Yes	No	Yes	No
a) Diabetes, prediabetes, or elevated sugar in urine; gestational diabetes; disease of the thyroid or pituitary gland; Grave's Disease; Addison's Disease; Cushing's Syndrome; insulin dependent diabetes; or any other disease or disorder of the endocrine system?	◯	◯		
b) High blood pressure (hypertension); palpitations or irregular pulse; chest pain or angina; atrial fibrillation; pericarditis; heart murmur; heart valve disease or disorder; coronary artery disease; heart attack; pacemaker; defibrillator; heart failure or other circulatory disorder?	◯	◯		
c) Stroke or TIA; epilepsy; seizures; multiple sclerosis; brain or spinal cord injury; paralysis related to injury or disease; ALS; recurrent loss of consciousness or dizziness or tremors; headaches; Guillain-Barre Syndrome; Parkinson's disease; dementia; Alzheimer's disease or hydrocephalus; or other disorder of the brain or neurological system?	◯	◯		
d) COPD; emphysema; asthma; shortness of breath; wheezing or chronic cough; chronic pneumonia or bronchitis; tuberculosis; cystic fibrosis; pulmonary edema or sarcoidosis; sleep apnea or other sleep disorder; other disorder of the lungs or respiratory system?	◯	◯		
e) Gastrointestinal ulcer; GERD; Barrett's Esophagus; disorder of the esophagus; ulcerative colitis or Crohn's disease; irritable bowel syndrome; disease or disorder of the liver including hepatitis or cirrhosis; liver recipient; chronic pancreatitis; rectal bleeding or blood in the stool?	◯	◯		
f) Blood or clotting disorder; thrombophlebitis; hemophilia; idiopathic thrombocytopenic; essential thrombocytosis; purpura or hemochromatosis; von Willebrand disease; other blood disorder including anemia? A blood disorder does not include a disorder related to Human Immunodeficiency Virus (HIV), Acquired immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).	◯	◯		
g) Disease or disorder of the kidney or bladder; kidney recipient; chronic kidney disease; renal failure; polycystic; blood; sugar; protein or albumin or other urine abnormalities; disorder of the prostate including elevated prostate specific antigen (PSA)?	◯	◯		
h) Tumor or disease of the breast or reproductive organs; abnormal pap smear/mammogram; pelvic inflammatory disease; uterine fibroids/cysts; PCOS or other abnormality of the menstrual cycle?	◯	◯		
i) Autoimmune or connective tissue disorder; lupus or other autoimmune disorder; rheumatoid arthritis; transverse myelitis; fibromyalgia; mixed connective tissue disease; sarcoidosis; Sjogren's Syndrome or Dupuytren's contracture?	◯	◯		
j) Disease or disorder of the joints, muscles, back or bones; osteoarthritis resulting in joint replacement; carpal tunnel syndrome; neck/back pain; spinal stenosis; sciatica; amputation or Paget's Disease?	◯	◯		
k) Cancer, including leukemia; lymphoma or Hodgkin's disease; mastocytosis; bone cancer; melanoma or other skin cancer; blood cancer; breast, brain, lung, liver, kidney, thyroid, pituitary, rectal, eye, prostate, ovarian, cervical, or bladder; tumor or other growth of cyst of any kind not diagnosed as benign?	◯	◯		
l) Disorder of the eyes other than myopia or astigmatism; retinal detachment or hemorrhage; iritis; uveitis; chronic sinusitis; vocal cord paralysis; Meniere's Disease; chronic vertigo; tinnitus; disorder of the ears; nose or throat?	◯	◯		
m) Nervous or psychiatric disorder including personality disorder; major depression; bipolar disorder; schizophrenia; obsessive compulsive disorder; anxiety; ADD or ADHD or PTSD?	◯	◯		
n) Unintentional weight loss, loss of appetite or weight gain of more than 10 pounds in last 12 months?	◯	◯		

Medical Questions Section: Employee and Spouse Applying for Coverage Must Complete This Section.

The following questions are to the best of the knowledge and belief of the person applying for coverage.	**Employee**	**Spouse**
7. Within the past 7 years, has any person proposed for coverage:	Yes No	Yes No
a) Been advised, by a medical professional, to reduce consumption of alcohol or seek counseling for the use of alcohol or drugs; used cocaine; narcotics; opioids; barbiturates; amphetamines; hallucinogens or other controlled substances; or been arrested in connection with alcohol or drugs, or received treatment in connection with alcohol or drugs?	◯ ◯	
b) Pled guilty to, pled no contest to, or been convicted of a felony or have criminal charge(s) currently pending; or been convicted of a major moving violation; including DUI, reckless driving, or driving to endanger; or had your driver's license suspended? If yes, date(s): Provide details:	◯ ◯	

8. Within the past 5 years, has any person proposed for coverage:	**Employee** Yes No	**Spouse** Yes No
a) Had abnormal findings of a physical examination; electrocardiogram, X-ray; blood test (except those related to Human Immunodeficiency Virus (HIV), Acquired immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); or diagnostic test?	◯ ◯	
b) Had inpatient or outpatient surgery, or been hospitalized for any reason?	◯ ◯	
c) Been medically advised, by a medical professional, to have surgery not yet done?	◯ ◯	
d) Had any medical treatment, health or physical impairment, other chronic or congenital condition not otherwise mentioned?	◯ ◯	
e) Had any life or health insurance declined, postponed, or modified or had a waiver or extra premium added?	◯ ◯	
f) Been released from military for medical reasons?	◯ ◯	
g) Been out of work for more than five consecutive days due to an illness or injury?	◯ ◯	
h) Received payment for disability, illness or injury?	◯ ◯	

	Employee Yes No	**Spouse** Yes No
9. Has any person proposed for coverage been prescribed medications for any reason in the last 12 months? If Yes, please list medication name, dose, dates used, and condition used for, in the Detail Section.	◯ ◯	
10. Within the past 12 months has any person proposed for coverage used cigarettes, any vape products, or any other forms of tobacco? If yes, advise the type of tobacco used and number of packs per week or vape pens or vape cartridges per week	◯ ◯	
11. Is any person proposed for coverage pregnant? If Yes, Name of person: Expected delivery date:	◯ ◯	
12. Has any person proposed for coverage had any complications of pregnancy?	◯ ◯	

DETAIL SECTION: **Give Full Details For Each "Yes" Answer for Questions 1-12. If More Space is Needed, Attach a Separate Piece of Paper, Signed and Dated**						
Question #	Applicant Name	Diagnosis/ Condition	Date of Onset	Treatment and/or Medication(s)	Name, Complete Address and Phone # of Medical Provider	Date Last Seen

Authorization and Acknowledgement

I declare that all the statements made in this form are to the best of my knowledge and belief true and complete and that they are the basis on which insurance requested by me may be issued. I understand that I am completing an insurance application and that each response must be complete and accurate. I understand all statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy unless it is contained in a written statement signed by me and a copy of the statement is furnished to me and my personal representative or my beneficiary.

I authorize any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, MIB Inc. (MIB), employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company), its reinsurers, or Third Party Administrator, any medical and non-medical information or records that they may have concerning my health condition, or health history, or information regarding any advice, care or treatment provided to me. My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS (Information sought pursuant to this authorization includes whether the applicant has tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection. Information should not be provided regarding whether the applicant has tested for or has received a negative result from a specific test for exposure to the HIV infection or for a sickness or condition derived from such infection), psychotherapy, reproductive, communicable disease and health care program information. This information will be used to determine my eligibility for benefits.

This authorization shall remain valid and apply to all records and information, for a period not to exceed 12 months. I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) fraud or overinsurance detection bureaus; (c) for audit or statistical purposes; (d) as may be required or permitted by law; or (e) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I request the indicated group coverage for myself and, if applicable, for my Dependents. I have not given the agent; or, any other persons any health information not included on this form. I understand that the Company is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that I have read or have had read to me this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that subject to any Deferred Effective Date provision(s) coverage will not take effect until the Company grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with this application.

Each applicant agrees that the electronic or type written signature, if included below, is intended to authenticate the application and to have the same force and effect as a handwritten signature.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature and Date for Person(s) Applying for Coverage (If not signed and dated by those applying for coverage, the application will be returned unprocessed.)		**Communication Preference** (If not checked, paper will be used)
Employee Signature:	Date:	◯ Email ◯ Paper (US Post Office)
Spouse Signature:	Date:	☐ Email ☐ Paper (US Post Office)

Return form to: Group Medical Underwriting Services, PO Box 31330 Salt Lake City, UT 84131
Fax: 1-855-290-5224
Email: eoi_underwriting@uhc.com

Evidence of Insurability Information and Privacy Practices Notice (Effective: July 7, 2023)

We[1] (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your "Protected Information" (i.e., personally identifiable information (PII) or protected health information (PHI)). For the purposes of this notice, "Protected Information" means information about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all the Protected Information in the Evidence of Insurability ("EOI") Form, and, if necessary, confirm or update this Protected Information in the ways described in this notice.

Information We Collect

Depending upon the Protected Information provided in your EOI Form, we may request additional information from you or another source. For example, we may:

- Ask you to have a physical exam, an EKG and/or other types of diagnostic testing (e.g., blood and/or urinalysis tests).
- Ask physicians, hospitals, or other healthcare providers to confirm or add to the information that you have given to us.
- Obtain information from the MIB, LLC. See "MIB Notice" below.
- Obtain information from pharmacy benefit managers and/or a consumer reporting agency.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Disclosure of Information

The authorization form that you have been asked to complete will permit us to send the Protected Information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with UnitedHealthcare Insurance Company or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the Protected Information we have about you may be disclosed to third parties without your specific permission.

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Access to Information

If you request in writing, we will send you a copy of the relevant Protected Information we obtain about you in connection with your request for coverage. Medical records, however, will only be disclosed through the attending licensed physician.

If you feel that any of the Protected Information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this Protected Information to anyone.

[1]UnitedHealthcare Insurance Company and Unimerica Life Insurance Company, or their reinsurers, may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Confidentiality and Security

We maintain physical, electronic, and procedural safeguards, in accordance with applicable state and Federal standards, to protect your Protected Information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your Protected Information.

Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the Federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

MIB Notice

In conjunction with our membership in MIB, you authorize us or our reinsurers to make a brief report of your personal health information to MIB, for the purposes described in this notice. Information regarding your insurability will be treated as confidential. We or our reinsurers may make a report of your Protected Information to MIB, which operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, MIB, upon request, will supply such company with information regarding you that it has in its file.

Upon receipt of a request from you, MIB will arrange for disclosure of any information it may have in your file. Please contact MIB at the number or website below. If you question the accuracy of information in MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Contact MIB at: MIB, LLC, 50 Braintree Hill Park Suite 400, Braintree, MA 02184- 8734, 1-866-692-6901, www.mib.com.

Questions About this Notice

If you have any questions about this notice, you may contact Group Medical Underwriting Services at 1-866-615-8727 (TTY/RTT 711), select Option 3 at the prompt and then Option 1.

[1]UnitedHealthcare Insurance Company and Unimerica Life Insurance Company, or their reinsurers, may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.