UNUM.
Unum Life Insurance
Company of America

INSTRUCTIONS AND INFORMATION FOR COMPLETING THE Unum EVIDENCE OF INSURABILITY FORM

	Completed
1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance. Specify what coverage you are requesting. If you are unsure, check with your plan administrator.	☐
2. Make sure you have answered all the questions completely and accurately. If there are unanswered questions, the underwriting process will be delayed.	☐
3. If you have answered Yes to any of the health questions, provide the complete name and mailing address of the doctor or facility that has your medical records.	☐
4. Please include your work and home phone number, we may need to request additional information by telephone.	☐
5. Sign and date where indicated. Keep this page and last copy of the form for your records. Please send the completed form to your plan administrator or Unum representative.	☐

In order to evaluate your application we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your doctors. Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. These tests will be performed at your convenience and can be completed at your place of employment or home. We will notify you if any additional information is needed. Unum will pay for any additional information or tests needed to evaluate your application.

CAUTION: If your answers on the application are incorrect or untrue, Unum may deny benefits or rescind your insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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Unum Life Insurance Company of America, Portland, Maine
(hereinafter called "Company")

EVIDENCE OF INSURABILITY

Social Security No.	Applicant/Employee E-mail Address	Group Policy No.(s)	Individual Certificate No.

Applicant / Employee Name	Employer's Name
Home Address	Employer's Address
City State Zip	City State Zip

Date of Employment	Applicant Phone Number	Occupation	Annual Salary
__ __/__ __/__ __ __ __	(H) (W)		

Name Of Persons Applying For Coverage	Sex	Date Of Birth	Place Of Birth	Height	Weight
Applicant		__ __/__ __/__ __ __ __			
Spouse		__ __/__ __/__ __ __ __			
Child		__ __/__ __/__ __ __ __			
Child		__ __/__ __/__ __ __ __			
Child		__ __/__ __/__ __ __ __			

Approval Requested for:

- ☐ Applicant / Employee
- ☐ Dependent(s)

Coverages:

- ☐ Life $ _____
- ☐ LTD $ _____
- ☐ Portability $ _____
- ☐ STD $ _____
- ☐ Other _____

Type of Application

- ☐ Initial Request
- ☐ Late Applicant
- ☐ Increase - Indicate Prior Amount of Coverage in Force $ _____

The following questions apply to all persons applying for coverage:

1. During the past 7 years have you been diagnosed or received treatment from a member of the medical profession for any heart disorder, high blood pressure, stroke, cancer, tumor, diabetes, alcoholism, kidney or liver disease, AIDS, AIDS Related Complex, respiratory, mental, nervous condition or emotional disorder, arthritis, strained or injured back, slipped disk or any bone, joint or muscle disorder?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

2. Are you currently using or have you ever used barbiturates, amphetamines, cocaine, hallucinogenic drugs, or any narcotics except as prescribed by a doctor or been advised to reduce your consumption of alcohol or been treated, arrested in connection with alcohol, or been told to have counseling for the use of alcohol or drugs?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

3. Do you have any condition which prevents or limits work, school attendance or usual activities or are you now pregnant?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

4. Do you take prescription drugs or medications for any physical, mental, nervous condition or emotional disorder?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

5. During the past 5 years, other than for conditions listed above, have you consulted or been treated by a member of the medical profession or been hospitalized?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

6. Do you have any health symptoms or complaints for which you have not consulted a member of the medical profession or received treatment?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

7. Have you applied for or been issued insurance which has been declined, rated up, modified or renewal refused?

Applicant / Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

Please provide details of yes answers below. If additional space is required, please use a separate sheet.

Question No.	Name	Problem/History - If For Blood Pressure Give Recent Reading	Date	Duration	Treatment	Names and Addresses of Physicians, Doctors and Hospitals
			__ __/__ __/__ __ __ __			
			__ __/__ __/__ __ __ __			
			__ __/__ __/__ __ __ __			
			__ __/__ __/__ __ __ __			
			__ __/__ __/__ __ __ __			

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy for which Evidence of Insurability is required. I have read and understand the Authorization and Disclosure Statements on the back and have received a copy.

__ __/__ __/__ __ __ __
Applicant / Employee Signature Date

__ __/__ __/__ __ __ __
Spouse Signature Date

Signature of children applying, 18 or older

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City State Zip	City State Zip

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Name Of Persons Applying For Coverage	Sex	Date Of Birth	Place Of Birth	Height	Weight
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__ __/__ __/__ __ __ __
Applicant / Employee Signature Date

__ __/__ __/__ __ __ __
Spouse Signature Date

Signature of children applying, 18 or older

1186-94

APPLICANT / EMPLOYEE COPY

(4/00)

Authorization to Obtain Information

I authorize any person or organization to give Unum or Unum's legal representative any of the following:

- information about any injury or illness I have or I have had, including any and all information on HIV infection, including AIDS, AIDS Related Complex (ARC), mental illness or drug or alcohol abuse;
- information about my medical history including any consultations, prescriptions, treatments or benefits;
- copies of all records that may be requested concerning me or my family members, and
- non-medical information about me or my family members.

The term person or organization, which is used above, means any of the following:

- a doctor or medical practitioner;
- a hospital, clinic or other medical treatment facility;
- the Medical Information Bureau, Inc.;
- any insurance or reinsurance company;
- any insurance support or reporting agency;
- any pharmacy;
- any government agency;
- any employer.

I understand that the information obtained by use of this authorization will be used by Unum to determine eligibility for insurance and eligibility for benefits. Unum will not release any of the obtained information to any other person or organization except:

- reinsuring companies
- the Medical Information Bureau, Inc.
- persons or organizations performing business or legal services in connection with my application or claim as may be
- otherwise lawful required or, as I may further authorize.

I understand that this authorization shall be valid for two years from the date shown on the application and that a photographic copy of this authorization shall be as valid as the original.

Disclosure

Notice of Insurance Information Practices

The information collected about you by Unum may in certain circumstances be disclosed to third parties without your specific authorization as permitted by law. You have a right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of Unum's information practices please contact Unum, Attn: Group Medical Underwriting, 2211 Congress Street, Portland, ME 04122.

Medical Information Bureau, Inc. Disclosure

Information regarding insurability will be treated as confidential. Unum may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of the life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or if you submit a claim for benefits to such a company, the Bureau will supply the company with the information in its file if that information is requested.

Unum or its reinsurers may also release information in the Bureau file to other life insurance companies to whom you may apply for life or health insurance or to whom you submit a claim for benefits.

If you request it, the bureau will arrange disclosure of any information it may have in your file. However, medical information will be disclosed only to your doctor. If you question the accuracy of information in the Bureau's file, you may contact the bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112. The telephone number is (617)426.3660.

The purpose of the Bureau is to protect its member companies and their policyholders from bearing the additional cost of providing coverage to those people who attempt to conceal facts which relate to their eligibility. Information furnished by the Bureau may alert the insurer to the possible need for further investigation, but it should be noted that any information received from the Bureau cannot be used as the basis for evaluating a person proposed for coverage. The Bureau is not a repository of medical records, and the information in its files does not reveal whether previous applications for coverage have been accepted, rated for extra risk, or declined.