

INSTRUCTIONS AND INFORMATION FOR COMPLETING THE Unum EVIDENCE OF INSURABILITY FORM

		Completed
 Fully complete this form when your plan requires you t underwritten to qualify for insurance. Specify what coverequesting. If you are unsure, check with your plan address. 	erage you are	
 Make sure you have answered all the questions compl If there are unanswered questions, the underwriting predelayed. 	,	
 If you have answered Yes to any of the health question complete name and mailing address of the doctor or fa medical records. 	· •	
 Please include your work and home phone number, w request additional information by telephone. 	e may need to	
 Sign and date where indicated. Keep this page and las your records. Please send the completed form to your 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.

1186-94

	, Applicant Li	nployee E-mail Address	Group Folicy No	.(s) Ind	ividual Certific	cate No.	Approval Requested for:
Applicant / Employee Name		Employer's Name					☐ Applicant / Employee
Applicant / Employee Name		Employers Name					☐ Dependent(s)
Home Address		Employer's Addres	s				Coverages:
							☐ Life \$
City State	Zip	City	State	Zip			☐ LTD \$
	cant Phone Number		Occ	cupation	Ann	ual Salary	Portability \$
/(H)		(W)					☐ STD \$
Name Of Persons Applying For Cove	erage Sex	Date Of Birth	Place	Of Birth	Height	Weight	☐ Other
Applicant		/					Type of Application
Spouse							☐ Initial Request
Child							☐ Late Applicant
Child		/					☐ Increase - Indicate Prior Amount of
		//					Coverage in Force
Child		///					\$
The following questions ap	ply to all perso	ns applying for co	overage:				
2. Are you currently using or have	ve you ever used l		mines, cocaine	, hallucino		, or any nare	
doctor or been advised to red for the use of alcohol or drugs		ption of alcohol or be	en treated, arre	sted in cor	nnection with	n alcohol, or	r been told to have counseling
for the use of alcohol of alage		eant / Employee: 🗆	Yes 🗆 No	Spou	se: 🗆 Yes	□ No	Child: Yes No
3. Do you have any condition wh	hich prevents or li	mits work, school atte	endance or usua	al activities	or are you	now pregna	nt?
	Applic	ant / Employee: 🔲	Yes 🗆 No	Spou	se: 🗆 Yes	□ No	Child: Yes No
4. Do you take prescription drug	o or modications	for any physical, men	tal nanyaya aa	ndition or e	motional di		
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20 you take propoription drug		cant / Employee:			se: Yes		Child: Yes No
5. During the past 5 years, other	Applic	cant / Employee:	Yes 🗆 No	Spou	se: 🗆 Yes	□ No	
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Unum Life Insurance Company of America, Portland, Maine (hereinafter called "Company")

Dependent(s) Depe			/ прриодиту Еттри	oyee L-mail Address	Group Policy No.(s)	Individual C	ertificate No.	Approval Requested for:
Life S Life S Life S Life S Life S Life S	Applicant /	/ Employee Name		Employer's Name		<u> </u>		☐ Applicant / Employee ☐ Dependent(s)
City State Zip City State Zip City State Zip City Cocupation	Home Adc	dress		Employer's Addres	SS		<u> </u>	Coverages:
The following questions apply to all persons applying for coverage: During the past 7 years have you been diagnosed or received treatment of the medical profession for any heart disorder, high blood pressure, stroke, carror, tump? diabets, alcoholins, kidney or liver disease, AIDS, AIDS Related Complex, respiratory, mental, nervous condition 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 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 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 readed and the medical profession for any heart disorder, high blood pressure, stroke, carnoer, tump? 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 5. During the past 5 years, other than for conditions 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 received readers. Applicant / Employee: Yes No Spouse: Yes No Child: Yes No 5. During the past 5 years, other than for conditions for suphysical, mental, nervous condition or remotional disorder? Applicant / Employee: Yes No Spouse: Yes No Child: Yes No 5. Do you have any health symptoms or complaints for which you have not consultated an emember of the medical profession or received readers. Applic	<u> </u>	A				7.		☐ Life \$
Applicant / Employee: Yes No No No No No No No N	City	State	Ζιp	City	State	∠ip		□ LTD \$
The following questions apply to all persons applying for coverage: 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 cemotional 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	Date of Em		Phone Number	440	Occupa	tion	Annual Salary	Portability \$
Applicant	/		e Sex		Place Of	Birth Heigh	t Weight	☐ STD \$
Type of Application Initial Request Late Application Initial Request Late Applicant Initial Request Late Applicant Late Applicant Initial Request Late Applicant Late Applicant Initial Request Late Applicant Late Appl		——————————————————————————————————————						☐ Other
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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, turnor, 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 Applicant / Employee: Yes No Spouse: Yes No Child: Yes No No Spouse: Yes No Child: Yes No No Spouse: Yes No Spouse:				//				`
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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. Duestion Name Problem/History - If For Blood Pressure Give Recent Reading Duration Treatment Names and Addresses of Physocomology. Note: No								
Duestion Name Problem/History - If For Blood Pressure Give Recent Reading Duration Treatment Names and Addresses of Phys Doctors and Hospitals	1. Do you	u take prescription drugs of the past 5 years, other tha alized?	Applican r medications for Applican an for conditions I Applican as or complaints	any physical, men at / Employee: iisted above, have at / Employee: for which you have	Yes No Ital, nervous condit Yes No you consulted or b Yes No not consulted a m	Spouse: ion or emotional Spouse: een treated by Spouse: ember of the management o	Yes No al disorder? Yes No a member of the Yes No medical profession	Child: Yes No Child: Yes No me medical profession or been Child: Yes No on or received treatment?
No. Pressure Give Recent Reading Doctors and Hospitals	4. Do you 5. During hospita 6. Do you	u take prescription drugs of the past 5 years, other that alized? u have any health symptom	Applican r medications for Applican an for conditions I Applican as or complaints to Applican ued insurance wh	any physical, men at / Employee: iisted above, have at / Employee: for which you have at / Employee: at / E	I Yes	Spouse: ion or emotiona Spouse: een treated by Spouse: ember of the m Spouse: diffied or renewa	Yes No al disorder? Yes No a member of the Yes No nedical profession Yes No al refused?	Child: Yes No Child: Yes No re medical profession or been Child: Yes No on or received treatment? Child: Yes No
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 coverage under the group policy for which Evidence of Insurability is required. I have read and understand the Authorization and Discl	I. Do you During hospita Do you Have y	u take prescription drugs of the past 5 years, other tha alized? u have any health symptom you applied for or been issu	Applican r medications for Applican an for conditions I Applican as or complaints t Applican ued insurance wh	any physical, men at / Employee: iisted above, have at / Employee: for which you have at / Employee: iich has been decli at / Employee:	I Yes	Spouse: ion or emotiona Spouse: een treated by Spouse: ember of the m Spouse: diffied or renewa Spouse:	Yes No al disorder? Yes No a member of the Yes No nedical profession Yes No al refused? Yes No	Child: Yes No Child: Yes No re medical profession or been Child: Yes No on or received treatment? Child: Yes No Child: Yes No
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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.