# INSTRUCTIONS AND INFORMATION FOR COMPLETING THE EVIDENCE OF INSURABILITY FORM

Unum Life Insurance Company of America

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.

To expedite processing, this form has been designed to be scanned and optically read. Please print neatly and respond to all questions.

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. Information pertaining to your Employer name, address and Group number, as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.

3. All employees and spouses applying for any coverage requiring underwriting must answer all health questions through section 2. If you are applying for disability coverage, or your life amount requiring underwriting is greater than $150,000, you must also fll out section 3.

4. Please include your work and home phone number; we may need to request additional information by telephone.

5. Please sign and date where indicated and make a copy of this form for your records. Please send the completed form to your plan administrator or mail the form directly to:

   Unum
   P.O. Box 9783
   Portland, ME 04104-5083

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 physicians. 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 benefts 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.



Reset

# EVIDENCE OF INSURABILITY

Unum Life Insurance Company of America

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Annual Enrollment
☐ Change in Status ☐ Increase ☐ Portability

List Your Current Height ___ - ___ (Ft. / In.) Weight ___ (Lbs.)

List Your Spouse's Current Height ___ - ___ (Ft. / In.) Weight ___ (Lbs.)

Employee Social Security Number ___ - ___ - ___ Gender ☐ Male ☐ Female

Group # ___ Group # ___ Division # ___

Employee First Name M.I. Last Name

Date of Birth - mm/dd/yyyy

## Details for any “yes” answers

| Question Number | Name | Detailed Description | Date | Duration | Treatment Received and Recovery | Names and Addresses of Physicians and Hospitals |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |

Please attach additional sheet if you need additional space

## Authorization

I authorize any person or organization to give Unum subsidiaries or their duly authorized representatives (Unum) any of the following:

- information about any injury or illness I have or I have had, including Acquired Immune Deficiency Syndrome (AIDS), mental illness or drug or alcohol abuse. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results. Such test results shall not be disclosed or published. I understand that nothing in this caveat will prohibit this authorization from including the fact that an applicant has Acquired Immune Deficiency Syndrome (AIDS).
- 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 a physician or medical practitioner, a hospital, clinic or other medical treatment facility, any insurance or reinsurance company, insurance support or reporting agency, pharmacy, government agency, or 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 or other persons or organizations performing services in connection with my application or claim.

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. I understand that I have the right to revoke this authorization at any time except to the extent it has been relied on prior to written notice of revocation. I also understand that, if I revoke this authorization, such revocation may be a basis for denying insurance benefits. This authorization may be revoked by sending written notice to: Unum, Attn: Group Medical Underwriting, P.O. Box 9783, Portland ME 04104-5083.

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 I and my authorized representative have a right to receive a copy. I understand that failure to sign this Authorization may impair Unum’s ability to process my application or evaluate a claim, and that this may be a basis for denying my application or claim for benefits.

_____ _____ _____ _____

Employee Signature Date Spouse Signature Date

_____ _____

Child Signature (if 18 or older) Date

8QXP XQGHUVWDQGV \RXU SULYDF\ LV LPSRUWDQW :H YDOXH R
WR SURWHFWLQJ WKH FRQÀGHQWLDOLW\ RI WKH SHUVRQDO LQIRUPDWLRQ
FROOHFW 13, ZKDW ZH GR ZLWK 13, DQG KRZ ZH SURWHFW \RX

:H FROOHFW 13, DERXW RXU FXVWRPHUV WR SURYLGH WKHP ZL
LQFOXGH WHOHSKRQH QXPEHU DGGUHVV GDWH RI ELUWK RFF
FHLYH 13, IURP \RXU DSSOLFDWLRQV DQG IRUPV PHGLFDO SUR
VXSSRUW RUJDQL]DWLRQV DQG VHUYLFH SURYLGHUV

:H VKDUH WKH W\SHV RI 13, GHVFULEHG DERYH SULPDULO\ ZLW
DQG SURIHVVLRQDO VHUYLFHV IRU XV VXFK DV KHDOWKFDUH SD
13, ZLWK PHGLFDO SURYLGHUV IRU LQVXUDQFH XQGHUZULWLQJ
DQFH VXSSRUW RUJDQL]DWLRQ 7KH RUJDQL]DWLRQ PD\ UHWDL
LW SHUIRUPV VHUYLFHV ,Q FHUWDLQ FDVHV ZH PD\ VKDUH 13,
DXGLWLQJ SXUSRVHV :H PD\ VKDUH 13, ZLWK SDUWLHV WR D S
RU IRU VWXG\ SXUSRVHV :H PD\ DOVR VKDUH 13, ZKHQ RWKHUZ
VKDULQJ ZLWK JRYHUQPHQWDO RU RWKHU OHJDO DXWKRULWLHV

:H KDYH SK\VLFDO HOHFWURQLF DQG SURFHGXUDO VDIHJXDUG
13, :H JLYH DFFHVV RQO\ WR HPSOR\HHV ZKR QHHG WR NQRZ W
VHUYLFHV WR \RX

<RX PD\ UHTXHVW DFFHVV WR FHUWDLQ 13, ZH FROOHFW WR SU
YLFHV <RX PXVW PDNH \RXU UHTXHVW LQ ZULWLQJ DQG VHQG
FOXGH \RXU IXOO QDPH DGGUHVV WHOHSKRQH QXPEHU,DQGRXS
UHTXHVW ZH ZLOO VHQG FRSLHV RI WKH 13, WR \RX ,I WKH 13
WKH KHDOWK LQIRUPDWLRQ WR \RX WKURXJKHDZLHOOOWKVRDUHQS
LQIRUPDWLRQ UHODWHG WR GLVFORVXUHV :H PD\ FKDUJH D UH

7KLV VHFWLRQ DSSOLHV WR 13, ZH FROOHFW WR SURYLGH \RX
OHFW LQ DQWLFLSDWLRQ RI D FODLP RU FLYLO RU FULPLQDO S

,I \RX EHOLHYH 13, ZH KDYH DERXW \RX LRXLQFRUWHFW VRXOG
IXOO QDPH DGGUHVV WHOHSKRQH QXPEHU DQG S<RXLF\OHXPEH
VKRXOG DOVR H[SODLQ ZK\ \RX EHOLHYH WKH 13, LV LQDFFXUD
13, DQG QRWLI\ \RX RI WKH FRUUHFWLRQ :H ZLOO DOVR QRWLI
UHFW 13, IURP XV LQ WKH SDVW WZR \HDUV LI \RX DVN XV WR F

,I ZH GLVDJUHH ZLWK \RX ZH ZLOO WHOO \RX ZHHDZULHOQRWY HR\R
UHDVRQ V IRU RXU UHIXVDO :H ZLOO DOVR WHOO<RXRX WKDW
VKRXOG LQFOXGH WKH 13, \RX EHOLHYH LV FRUUHFW ,W VKRXG
ZLWK RXU GHFLVLRQ QRW WR FRUUHFW WKH 13, LQ RXU ÀOHV
:H ZLOO LQFOXGH \RXU VWDWHPHQW DQ\ WLPH ZH GLVFORVH W
WR DQ\ SHUVRQ GHVLJQDWHG E\ \RX LI ZH PD\ KDYH GLVFORVH
WZR \HDUV

,I ZH GHFLGH QRW WR LVVXH FRYHUDJH WR \RX ZH ZLOO SURY
VLRQ :H ZLOO DOVR WHOO \RX KRZ WR DFFHVV DQG FRUUHFW

)RU DGGLWLRQDO LQIRUPDWLRQ DERXW 8QXPZ<ZZ F8RQXPL WRPHQW
RUZZZ FRORQLDOLZUHLWRPWR 3ULYDF\ 2IÀFHU 8QXP &RQJU
0DLQH :H UHVHUYH WKH ULJKW ZLOO PRGLI\ WKLV QRWLFH D
PDNH PDWHULDO FKDQJHV WR RXU SULYDF\ SUDFWLFHV

‹ 8QXP $OO ULJKWV UHVHUYHG 8QXP LV D UHJLVWHUHG WUDGHPDUN DQ
VXEVLGLDULHV 7KH LQVXUDQFH SURGXFW LV XQGHUZULWWHQ E\ 8QXP /LH