Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Evidence of Insurability (EOI)

Administrative Offices: **Downers Grove, Illinois | Dallas, Texas**

PART 1: TO BE COMPLETED BY GROUP ADMINISTRATOR/EMPLOYER (Please Print and submit with copy of employee enrollment form)

Group Number ____________________

Group Name and Address

Group Contact ____________________
(Print Name)

Group Contact ____________________
(Print Title)

Telephone (______) ____________________

Fax (______) ____________________

Reason for EOI:

- ❑ Amount over Guarantee Issue
- ❑ Late Enrollment
- ❑ Other ____________

If New Hire, Indicate Eligibility Waiting Period ____________

Policy Anniversary Date ____________

FOR DEARBORN NATIONAL USE ONLY

EMPLOYEE	SPOUSE	CHILD(REN)
❑ Approved ❑ Declined ❑ Closed ❑ Smoker ❑ Nonsmoker	❑ Approved ❑ Declined ❑ Closed ❑ Smoker ❑ Nonsmoker	❑ Approved ❑ Declined ❑ Closed
GI ❑Yes ❑No $__________	GI ❑Yes ❑No $__________	Amount Approved $__________ Effective Date* Reviewed by & date __________
Amount Approved $__________ Effective Date* Reviewed by & date __________	Amount Approved $__________ Effective Date* Reviewed by & date __________	State Code ________ Agency (CB)(TPA) __________ ❑ SAWEB ❑ Self-Admin ❑ Direct Bill ________

*The effective date of coverage is the date the application is approved. Premium is due the first of the month following the approval date. **Do not deduct premiums for any coverage subject to evidence of insurability until you receive Dearborn National's final confirmation of approval.**

PART 2: TO BE COMPLETED BY EMPLOYEE - This section contains essential information and leaving any item blank will cause a delay in processing your insurance request.

EMPLOYEE

Name Last	First	M.I.	Date of Birth	Age	Sex	State of Birth
			/ /		❑ M ❑ F	

Home Mailing Address - Street	City	State	Zip	Work Telephone	Home Telephone
				( )	( )

Social Security #	Height ft. in.	Weight lbs.

SPOUSE-DO NOT complete spouse information unless you are applying for dependent spouse coverage.

Name Last	First	M.I.	Date of Birth	Age	Sex	State of Birth
			/ /		❑ M ❑ F	

Social Security #	Height ft. in.	Weight lbs.

CHILD(REN) - DO NOT complete this section unless you are applying for dependent child(ren) life insurance which is subject to satisfactory evidence of insurability (for example, a late enrollment.) *Evidence of insurability is not required for voluntary dependent child term life coverage.*

Dependent Child Full Name	SS#	Date of Birth	Age	Sex	Ht & Wt
				❑ M ❑ F	
				❑ M ❑ F	
				❑ M ❑ F	

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.
Retain a copy of this application for your records.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

Part 3: Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

Check either **"Yes"** or **"No"** to each question and **circle the specific condition(s). Details to all "yes" answers must be provided below. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.**	**Employee** Yes No	**Spouse** Yes No	**Child(ren)** Yes No
1. Has any person applying for coverage been seen, treated, advised or received services from any health provider <u>in the last 12 months</u>, including routine physicals?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
2. Within the last 7 years, **has any person applying for coverage had symptoms, been diagnosed with and/or received treatment by/from a member of the health profession for any of the conditions listed in the questions below?**			
a. High blood pressure, heart attack, chest pain, shortness of breath, irregular heartbeat, murmur, coronary artery disease, heart surgery (catheterization/ angioplasty/bypass, etc.), or any other disease or disorder of the heart or circulatory system?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
b. Enlarged glands, thyroid disorder, diabetes, abnormal glucose level, hepatitis, cirrhosis, abnormal liver studies, hernia, ulcer, colitis or any other disease or disorder of the liver, endocrine, or digestive system?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia or any other mental/nervous/behavioral disorder?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
d. Asthma, emphysema, tuberculosis, pneumonia, COPD, sleep apnea, or any other disease or disorder of the throat, lungs, or respiratory tract?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
e. Prostate, uterus/tubes/ovaries, endometriosis, cystitis, kidney stone, renal failure, sexually transmitted diseases, any disorder of the kidneys/bladder/ urinary tract, breast lumps/changes/biopsies, abnormal test results or any other male/female disorder?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
f. Cancer, tumor, cyst, moles, polyps, growth or any skin disorder (indicate location and if benign/malignant)?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, or any other disease or disorder of the nervous system?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
h. Arthritis, gout, rheumatism, neck or back strain/sprain/injury, deformity, loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
3. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
4. Does any person applying for coverage currently take medication (prescription or otherwise), been prescribed medication, or has any person done so <u>in the last 6 months</u>?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
5. <u>Within the last 2 years</u>, has any person applying for coverage had a physical disability, surgery, or been confined to a hospital, skilled nursing or rehabilitation facility, undergone any special examinations or laboratory tests such as x-rays, electrocardiograms, MRI, CAT Scans, PET or CT Scans, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment; and/or been advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed, not mentioned in questions 1 through 3?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
6. Is any person applying for coverage <u>currently</u> pregnant? If **"Yes"**, indicate anticipated delivery date ______________. **Provide details of any current/ prior complications on Page 3.**	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
7. Has any person applying for coverage EVER HAD symptoms, been diagnosed with, and/or received treatment from a member of the health profession for ANY HEALTH CONDITION other than those conditions listed above?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

Employee Name ______________________________ Social Security #______________________

Part 3: (Continued): Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

	Employee Yes No	Spouse Yes No	Child(ren) Yes No
8. Has any person applying for coverage used cigarettes or other tobacco products in the last 2 years?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
9. Has any person applying for coverage been rated, declined, postponed or limited in any way for life, health, accident or disability insurance?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

PART 4: Provide details of all 'YES' answers given to questions in PART 3. – If additional space is required, attach a separate signed and dated sheet.

#	Person	Type of Condition	Dates	Hospitalized Yes No	Surgery Yes No	Treatment/ Medication	Current Meds/ Remaining Problems	Physician's Name, Address & Phone#

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

Evidence of Insurability (EOI)

Administrative Offices: **Downers Grove, Illinois | Dallas, Texas**

Employee Name ______________________________ Social Security #____________________

No premiums may be deducted on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by your employer from Dearborn National® Life Insurance Company.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

AGREEMENTS AND AUTHORIZATION: I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Dearborn National Life Insurance Company (Dearborn National) shall not be liable for any claim arising prior to the date of approval of this application at Dearborn National's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, clinic or other medical or medically-related facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn National's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize Dearborn National to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until Dearborn National approves my application, provided that I am actively at work on that day

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from Dearborn National.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, Dearborn National has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

______________________________ ____________________

Signature of Employee — Date

______________________________ ____________________

Signature of Spouse (if requesting insurance) — Date

______________________________ ____________________

Signature of Dependent Child (if to be insured and of age of majority) — Date

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.