



**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 fill 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 or fax the form directly to:

GEBA
P.O. Box 206
Annapolis Jct, MD 20701-0206
Fax: 301-688-6694

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 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.

Reorder as CU-3724 (11/08)



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

Height input fields: Ft., In.

Weight

Weight input fields: Lbs.

List Your Spouse's Current Height

Spouse Height input fields: Ft., In.

Weight

Spouse Weight input fields: Lbs.

Employee Social Security Number

Employee Social Security Number input fields

Gender

[] Male [] Female

Group #

Group # input fields: 5 9 2 3 4 4

Group #

Group # input fields

Division #

Division # input fields

Employee First Name

Employee First Name input fields

M.I. Last Name

M.I. Last Name input fields

Date of Birth - mm/dd/yyyy

Date of Birth input fields

Spouse First Name (if applicable)

Spouse First Name input fields

M.I. Last Name

Spouse M.I. Last Name input fields

Spouse Date of Birth - mm/dd/yyyy

Spouse Date of Birth input fields

Number & Street Address

Number & Street Address input fields

Employee Home Number

Employee Home Number input fields

City

City input fields

State

State input fields

Zip Code

Zip Code input fields

Employee Work Number

Employee Work Number input fields

Date of Employment - mm/dd/yyyy Occupation

Date of Employment and Occupation input fields

Employee Annual Salary

Employee Annual Salary input fields

E-mail Address

E-mail Address input fields

Coverages Elected

[] Life [] LTD [] STD

Employer's Name

Employer's Name input fields

Employer's Address

Employer's Address input fields

City

City input fields: A n n a p o l i s J c t

State

State input fields: M D

Zip Code

Zip Code input fields: 2 0 7 0 1

Employee

Total Life Amount Applied For

Employee Total Life Amount Applied For input fields

Amount Requiring Underwriting

Employee Amount Requiring Underwriting input fields

Spouse

Total Life Amount Applied For

Spouse Total Life Amount Applied For input fields

Amount Requiring Underwriting

Spouse Amount Requiring Underwriting input fields

Names of Dependent Children Applying for Coverage

Child Name input fields

Date of Birth - mm/dd/yyyy

Child Date of Birth input fields

Total Life Amount

Child Total Life Amount input fields

Child

Child Name input fields

Child Date of Birth input fields

Child Total Life Amount input fields

Child

Child Name input fields

Child Date of Birth input fields

Child Total Life Amount input fields

Child

Please answer the following questions to the best of your knowledge and belief:

<p>Has any person applying for coverage been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Applicant need not disclose Human Immunodeficiency Virus (HIV) test results.</p>	<p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>Section 1 Dependent Children Health Questions</p>									
<p>1. Within the past 5 years, have any dependent(s) been treated for diabetes, heart disorder, or cancer (other than basal or squamous cell carcinoma of the skin)? Do any dependent(s) have cerebral palsy, cystic fibrosis or muscular dystrophy? If yes, please provide name(s) of children.</p>	<p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>Section 2 Employee and Spouse Health Questions</p>									
<p>All employees and spouses applying for coverage must complete this section.</p>	<table border="1"> <thead> <tr> <th colspan="2">Employee</th> <th colspan="2">Spouse</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> </thead> </table>	Employee		Spouse		Yes	No	Yes	No
Employee		Spouse							
Yes	No	Yes	No						
<p>1. Within the past 2 years, have you used any controlled substances with the exception of those prescribed by a physician, received medical advice or sought treatment for drug or alcohol abuse, or pled guilty, pled no contest to or been convicted of a felony, misdemeanor, or a charge of operating a motor vehicle under the influence of drugs and/or alcohol?</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>2. Within the past 2 years, have you been prescribed three or more medications to be taken concurrently for high blood pressure?</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>3. Within the past 5 years, have you received medical advice or sought treatment for psychosis, internal cancer including melanoma, leukemia or Hodgkin's disease, ALS, muscular dystrophy, angina, or had heart surgery, heart attack or transient ischemic attack (TIA)?</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>4. Within the past 10 years, have you received medical advice or sought treatment for stroke, congestive heart failure, chronic lung disease including emphysema, diabetes treated with insulin or oral medications, hepatitis (other than type A), cirrhosis of the liver, chronic renal disease including hypertension or failure, systemic lupus or any connective tissue disease?</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>5. Are you confined to a wheelchair for reasons other than paraplegia?</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>Section 3 If your amount requiring underwriting is greater than \$150,000 or you are applying for disability coverage, you must complete section 3. Otherwise, please sign and return application.</p>									
<p>If you answer yes, please provide details requested in the box on the following page.</p>	<table border="1"> <thead> <tr> <th colspan="2">Employee</th> <th colspan="2">Spouse</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> </thead> </table>	Employee		Spouse		Yes	No	Yes	No
Employee		Spouse							
Yes	No	Yes	No						
<p>1. Within the past 2 years, have you flown as a student or private pilot, engaged in auto or boat racing, scuba diving, hang gliding, ballooning, flying ultralights, parachuting, mountain climbing or any similar sport or avocation?</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>2. Have you ever used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician 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? If yes, provide the frequency of use and date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number, date of occurrence and driver's license number and issuing state of any arrest.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>3. Have you ever pled guilty to, pled no contest to or been convicted of a felony or misdemeanor? If yes, list person's name, reason for arrest(s) and/or are you currently on probation.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>4. Within the past 2 years, have you pled guilty to, pled no contest to, or been convicted of 3 or more speeding or other moving violations? If yes, list person's name, type of violation(s) and date(s), driver's license number and state of issue.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>5. Within the past 10 years, have you received medical advice or sought treatment for epilepsy, nervous, emotional or mental disorder, paralysis, skin, bone, muscle, back, knee, neck or joint disorder, muscular or neurological disorders, Fibromyalgia, or Chronic Fatigue Syndrome. If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>6. Within the past 7 years, have you received medical advice or sought treatment for diabetes, asthma, lung or respiratory disorder, thyroid or other endocrine disease, heart or circulatory disorder, stroke (including TIA), chest pain, high blood pressure, cancer, gastro-intestinal, genitourinary, kidney or liver disease? If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>7. Within the past 7 years, have you consistently taken any over the counter medications, natural supplements other than vitamins, or received any therapeutic treatments? If yes, list all over the counter medications including any natural supplements, dosage, condition and date of onset. Please also list therapies and associated conditions and dates treatment received.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>8. Within the past 7 years, have any medications been prescribed or have you consulted a medical professional for anything other than the conditions above, or are you currently experiencing any symptoms for which you haven't consulted a medical professional? If yes, provide details including symptoms, dates of occurrence, medications, treatment and medical professional's name, address and phone number.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>9. Do you have any condition that prevents or limits activities or are you now pregnant? If yes, provide details including symptoms and describe the limitation(s). If pregnant, please provide expected delivery date.</p>	<table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Details for any "yes" answers

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

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