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 the form directly to:

   Unum
   P.O. Box 9783
   Portland, ME 04104-5083
   or Fax form to 1-207-771-4019

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: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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** / /

Spouse First Name (if applicable) **M.I.** **Last Name** **Spouse Date of Birth - mm/dd/yyyy** / /

Number & Street Address

Employee Home Number ( ) -

City **State** **Zip Code**

Employee Work Number ( ) -

Date of Employment - mm/dd/yyyy / /

Occupation

Employee Annual Salary $, ,

E-mail Address

Coverages Elected ☐ Life ☐ LTD ☐ STD

Employer's Name

Employer's Address

City **State** **Zip Code**

Employee		Spouse	
Total Life Amount Applied For	Amount Requiring Underwriting	Total Life Amount Applied For	Amount Requiring Underwriting
$, ,	$, ,	$, ,	$, ,

Names of Dependent Children Applying for Coverage	Date of Birth - mm/dd/yyyy	Total Life Amount
Child	/ /	$,
Child	/ /	$,
Child	/ /	$,

1510939905425

9936294428

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

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.	☐ **Yes** ☐ **No**
Section 1 Dependent Children Health Questions	
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.	☐ **Yes** ☐ **No**

Section 2 Employee and Spouse Health Questions	**Employee**		**Spouse**	
All employees and spouses applying for coverage must complete this section.	**Yes**	**No**	**Yes**	**No**
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?	☐	☐	☐	☐
2. Within the past 2 years, have you been prescribed three or more medications to be taken concurrently for high blood pressure?	☐	☐	☐	☐
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)?	☐	☐	☐	☐
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?	☐	☐	☐	☐
5. Are you confined to a wheelchair for reasons other than paraplegia?	☐	☐	☐	☐

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.	**Employee**		**Spouse**	
If you answer yes, please provide details requested in the box on the following page.	**Yes**	**No**	**Yes**	**No**
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?	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐

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

Unum
Attn: Medical Underwriting
P.O. Box 9783
Portland, ME 04104-5083

NOTE: Please sign and return this authorization to the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

AUTHORIZATION

I authorize any person or organization to give Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, Unum Insurance Company, or their duly authorized representatives or subsidiaries (individually or collectively referred to as "Unum") any of the following:

- Information about any condition, injury, or illness I have or may have had, including: disorders of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS); mental or physical history, condition, advice, or treatment (but not psychotherapy notes); drug or alcohol use. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results.
- Information about my medical history including any consultations, prescriptions or prescription drug history, treatments or benefits
- Information that may be requested concerning me or my family members, including non medical information such as driving record, consumer reports, earnings or employment history
- Information about other insurance coverage, claims, or benefits

The terms person or organization mean a physician or medical practitioner, a hospital, clinic or other medical facility, health plan, any insurance or reinsurance company, insurance service provider, third party administrator, producer, insurance support organization or consumer reporting agency, data sources, pharmacy or pharmacy benefit manager, government entity, motor vehicle agency, or employer.

I understand the information obtained with this authorization will be used by Unum to determine eligibility for insurance and benefits. Once my information is disclosed to Unum, privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum will not release any of the information to a third party except reinsuring companies or other persons or organizations performing services in connection with my application, coverage, or claim, or as otherwise permitted by law.

I understand that this authorization shall be valid for two years from its date and that a photographic or electronic copy 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 or alter this authorization, it may be a basis for denying insurance coverage or benefits. I can revoke this authorization by sending written notice to the address above.

I have read and understand this authorization, and I and my authorized representatives 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.

_____ _____
(Applicant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the applicant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

MK-1883 (11/16)