Dearborn Life Insurance Company

Coverage Election Summary for EOI

To be completed by Group Administrator/Employer
Attach this form with the completed Employee Application and return to:

Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 721-7987
Fax Number: (855) 691-7157

Complete all blanks and print clearly. Omitted information will cause consideration of coverage to be delayed.
*The effective date of coverage is the date the application is approved. Premium is due the first of the month following the approval date. **Group Administrator/Employer: Do not deduct premiums for any coverage subject to evidence of insurability until you receive Dearborn Life Insurance Company's final confirmation of approval.**

TO BE COMPLETED BY GROUP ADMINISTRATOR/EMPLOYER: (Print and submit with employee enrollment information.)

Employer Name		Group Number	Account No. _____ Location No. _____
Employer's Street Address		City	State / Zip Code
Employer Contact Name	Business Phone Number	Business Fax Number	Email Address
Employee Name (first, middle initial, last) _____	Social Security Number _____	Alternate ID _____	Coverage Request for: □ Employee □ Spouse □ Dependent Child(ren)*

*Evidence of Insurability is not required for supplemental or voluntary dependent child term life coverage for total benefit amounts of $10,000 or less.

Earnings: _____ □ Hourly □ Weekly □ Monthly □ Annually	Employee Date of Hire:	Employee Date of Rehire:	

REASON FOR EOI: □ Amount over Guarantee Issue □ Late Enrollment □ Annual Enrollment
□ Increase In Coverage □ Change in Status – Date _____ Reason: _____

Type of Coverage	Current Amount In-Force (if any)	Additional Amount Requested	Total Amount Requested
□ Basic Term Life	$	$	$
□ Supplemental/Voluntary Employee Term Life	$	$	$
□ Supplemental/Voluntary Spouse Term Life	$	$	$
□ Supplemental/Voluntary Dependent Child(ren) Term Life	$	$	$
□ Basic Short-Term Disability	$	$	$
□ Basic Long-Term Disability	$	$	$
□ Voluntary Short-Term Disability	$	$	$
□ Voluntary Long-Term Disability	$	$	$
□ Employee Critical Illness	$	$	$
□ Spouse Critical Illness	$	$	$
□ Dependent Child(ren) Critical Illness	$	$	$

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Dearborn Life Insurance Company

Evidence of Insurability Application

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

EMPLOYEE INFORMATION SECTION: (Complete even if Employee is not applying for coverage.)					
Name First MI Last			□ Male □ Female	Date of Birth (MM/DD/YYYY)	
Social Security Number	Alternate ID	State of Birth	Country of Birth		
Home Mailing Address Street			City	State	Zip Code
Preferred Method of Contact	Employee Telephone Number		Cell Phone Number		
Work Phone Number	Email Address		Occupation		

SPOUSE INFORMATION SECTION: (Complete only if applying for Spouse coverage.)			
Name First MI Last		□ Male □ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Preferred Method of Contact	Spouse Telephone Number	Cell Phone Number
Work Phone Number	Email Address	State of Birth	Country of Birth

DEPENDENT CHILD(REN) INFORMATION SECTION:
Employee must complete this section for each child applying for Supplemental or Voluntary life insurance coverage amounts greater than $10,000.

Child 1 **Name** First MI Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/YYYY)
Child 2 **Name** First MI Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/YYYY)
Child 3 **Name** First MI Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/YYYY)
Child 4 **Name** First MI Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/ YYYY)

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Employee Name _____ Social Security Number _____

HEALTH INFORMATION – Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "Yes" answers must be provided in section provided on page 3 below for any person applying for coverage. Omitted information will cause consideration of coverage to be delayed. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.

HEALTH QUESTIONS SECTION: (Complete only if applying for coverage.)

1. Employee Height _____ feet _____ in. Weight ____ lbs. Spouse Height ____ feet ____ in. Weight ____lbs.
2. **In the past 7 years,** has any person applying for coverage been diagnosed, treated, or given medical advice by a physician or other medical professional for:

	Employee		Spouse	
	Yes	No	Yes	No
a. Congestive heart failure, heart attack, stroke, paralysis, cirrhosis of the liver, Hepatitis (B or C), emphysema, or chronic obstructive pulmonary disease (COPD):	☐	☐	☐	☐
b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
c. Hodgkin's disease, leukemia, lymphoma, or malignant brain tumor?	☐	☐	☐	☐
d. Chronic kidney disease including failure, dialysis, transplant, or polycystic kidney disease?	☐	☐	☐	☐
e. Dementia, Alzheimer's disease, ALS (Lou Gehrig's Disease), Huntington's Chorea, multiple sclerosis, or muscular dystrophy?	☐	☐	☐	☐
f. Cancer, tumor, heart condition, high blood pressure, transient ischemic attack (TIA), aneurysm, neurological, or circulatory disorder?	☐	☐	☐	☐
g. Diabetes, systemic lupus, any autoimmune disorder, anemia or other blood disorder?	☐	☐	☐	☐
h. Gastrointestinal, respiratory, genitourinary, musculoskeletal, or connective tissue disorder?	☐	☐	☐	☐
i. Depression, anxiety, or any other mental/nervous disorder?	☐	☐	☐	☐
3. **In the past 5 years,** has any person applying for coverage received medical advice, sought treatment for drug or alcohol abuse (excluding support groups), used any controlled substances (except those prescribed by a physician or other medical professional), been convicted or charged with operating a motor vehicle under the influence of drugs or alcohol?	☐	☐	☐	☐
4. **In the past 6 months**, has any person applying for coverage:				
a. been hospitalized, advised to have surgery, treatment, diagnostic tests, or other evaluation?	☐	☐	☐	☐
b. been prescribed long term maintenance medications for chronic conditions?	☐	☐	☐	☐
5. Has any person applying for coverage used cigarettes or other tobacco in the last 2 years?	☐	☐	☐	☐

EMPLOYEE HEALTH QUESTIONS SECTION: (Complete in addition to Health Questions Section above if applying for DISABILITY coverage.)

1. Are you pregnant? If "Yes", Date Due: _____ Any complications or problems? ☐ ☐
2. **In the past 7 years,** have you been diagnosed or treated by a member of the medical profession for a disorder of the back, spine, neck, knee, bone or joint, arthritis, neurological disorder, fibromyalgia, chronic fatigue syndrome, or other musculoskeletal disorder? ☐ ☐

DEPENDENT CHILD(REN) HEALTH QUESTIONS SECTION:
Employee must complete this section for each child applying for Supplemental or Voluntary life insurance coverage amounts greater than $10,000.

1. Child 1. Height _____ feet _____ in. Weight _____ lbs. Child 2. Height _____ feet _____ in. Weight _____ lbs.
   Child 3. Height _____ feet _____ in. Weight _____ lbs. Child 4. Height _____ feet _____ in. Weight _____ lbs.

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Employee Name _____ Social Security Number _____

DEPENDENT CHILD(REN) HEALTH QUESTIONS SECTION (Continued):

2. **In the past 5 years,** has any dependent child applying for coverage been diagnosed, treated, given medical advice by a physician or other medical professional for:

	Dependent Child(ren) Yes	No
a. Diabetes, heart condition, cancer, cerebral palsy, cystic fibrosis, muscular dystrophy, autism, Down's syndrome, Intellectual and Developmental Disabilities, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the HIV virus? If "Yes", please provide name(s) of dependent child(ren). _____	□	□
b. **In the past 6 months**, has any dependent child applying for coverage been hospitalized, required emergency room evaluation, been advised to have surgery, treatment, diagnostic tests or other evaluation? If "Yes", please provide name(s) of dependent child(ren). _____	□	□

PROVIDE DETAILS OF ALL "YES" ANSWERS FROM ALL HEALTH QUESTION SECTIONS ABOVE (If applicable). If additional space is required, attach a separate signed and dated sheet.

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

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AGREEMENTS AND AUTHORIZATION: "I" refers to the person(s) applying for insurance, signing below. I hereby represent that the statements and answers to the question(s) are, to the best of my knowledge and belief, full, complete, true and correctly recorded, and will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. I understand Dearborn Life Insurance Company shall not be liable for any claim arising prior to the date of approval of this application at Dearborn Life Insurance Company's Home Office.

To determine my eligibility for the coverages applied for, I authorize any physician, medical professional, practitioner, hospital, clinic, other health facility, medical or medically-related facility, medical provider, mental health professional, pharmacy or pharmacy benefit manager, laboratory, insurance company, the MIB, 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 Life Insurance Company's underwriting department 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 medical history, pharmaceutical history, drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize Dearborn Life Insurance Company to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB, Inc., a not-for-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 by written notice, but that such a revocation will have no effect on any actions taken by Dearborn Life Insurance Company prior to receipt of the revocation;
- Information provided pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as 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 Life Insurance Company approves my application, provided that I am actively at work on that day;**
- **No premiums may be deducted by my Employer on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by my employer from Dearborn Life Insurance Company.**

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 Life Insurance Company.

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

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 may subject such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

Signature of Employee (required) _____ Date Signed (MM/DD/YYYY) _____

Signature of Spouse (if requesting insurance) _____ Date Signed (MM/DD/YYYY) _____

Signature of Dependent Child (if requesting insurance and at least 18 years of age)

Child 1 _____ Date _____ Child 2 _____ Date_____

Child 3_____Date _____ Child 4 _____ Date _____