



Application and return to:

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

Phone Number: (800) 367-6401
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 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, 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: Employee Date of Hire: Employee Date of Rehire:
Hourly Weekly Monthly Annually

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

Table with 4 columns: Type of Coverage, Current Amount In-Force (if any), Additional Amount Requested, Total Amount Requested. Rows include 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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**YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION TO BE CONSIDERED FOR COVERAGE.**  
**Retain a copy of this application for your records.**

<b>EMPLOYEE INFORMATION SECTION:</b> (Complete even if Employee is not applying for coverage.)							
<b>Name</b> First MI Last				<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (MM/DD/YYYY)	
Social Security Number		Alternate ID		State of Birth		Country of Birth	
<b>Home Mailing Address</b> Street				City		State	Zip Code
Preferred Method of Contact			Employee Telephone Number			Cell Phone Number	
Work Phone Number			Email Address			Occupation	
<b>SPOUSE INFORMATION SECTION:</b> (Complete only if applying for Spouse coverage.)							
<b>Name</b> First MI Last				<input type="checkbox"/> Male <input type="checkbox"/> 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	
<b>DEPENDENT CHILD(REN) INFORMATION SECTION:</b> Employee must complete this section for each child applying for Supplemental or Voluntary life insurance coverage amounts greater than \$10,000.							
<b>Child 1 Name</b> First MI Last				<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number	Date of Birth (MM/DD/YYYY)
<b>Child 2 Name</b> First MI Last				<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number	Date of Birth (MM/DD/YYYY)
<b>Child 3 Name</b> First MI Last				<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number	Date of Birth (MM/DD/YYYY)
<b>Child 4 Name</b> First MI Last				<input type="checkbox"/> Male <input type="checkbox"/> 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. <b>In the past 7 years</b> , has any person applying for coverage been diagnosed, treated, or given medical advice by a physician or an appropriately licensed clinical professional acting within the scope of their license for:  |                          |                          |                          |                          |
|  | <u>Employee</u>          | <u>Spouse</u>            |                          |                          |
|  | <u>Yes</u>               | <u>No</u>                | <u>Yes</u>               | <u>No</u>                |
| a. Congestive heart failure, heart attack, stroke, paralysis, cirrhosis of the liver, Hepatitis (B or C), emphysema, or chronic obstructive pulmonary disease (COPD):  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the HIV virus:   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hodgkin’s disease, leukemia, lymphoma, or malignant brain tumor?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chronic kidney disease including failure, dialysis, transplant, or polycystic kidney disease?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Dementia, Alzheimer’s disease, ALS (Lou Gehrig’s Disease), Huntington’s Chorea, multiple sclerosis, or muscular dystrophy?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer, tumor, heart condition, high blood pressure, transient ischemic attack (TIA), aneurysm, neurological, or circulatory disorder?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, systemic lupus, any autoimmune disorder, anemia or other blood disorder?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Gastrointestinal, respiratory, genitourinary, musculoskeletal, or connective tissue disorder?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Depression, anxiety, or any other mental/nervous disorder?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. <b>In the past 5 years</b> , has any person applying for coverage received medical advice, sought treatment for drug or alcohol abuse, 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. <b>In the past 6 months</b> , has any person applying for coverage:   |                          |                          |                          |                          |
| a. been hospitalized, advised to have surgery, treatment, diagnostic tests, or other evaluation?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. been prescribed long term maintenance medications for chronic conditions?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has any person applying for coverage used cigarettes or other tobacco in the last 2 years?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. <b>In the past 7 years</b> , 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? | <input type="checkbox"/> | <input type="checkbox"/> |

**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 an appropriately licensed clinical professional acting within the scope of their license 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 #

# Dearborn Life Insurance Company

## Evidence of Insurability Application

To be completed by the applicant

Return completed application and enrollment

information to:

Dearborn Life Insurance Company

Attn: Medical Underwriting Department

P.O. Box 7072

Downers Grove, IL 60515

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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.

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 \_\_\_\_\_