Group Accident Insurance
Instructions for
Evidence of Insurability Application

Application Type: Check off the applicable application type based on the following definitions:

- **Newly Eligible:** application for insurance on a newly eligible or newly hired employee. Usually an employee applying for this coverage for the first time.
- **Late Applicant:** application for insurance on a previously eligible employee. If you are working for employer in an eligible group and 31 days after the date you were eligible for coverage has passed. Requires completion of health questions in Section 4 if applying for the Hospital Confinement due to Covered Sickness Benefit.
- **Replace Existing Unum Coverage:** Change from existing to later or updated version of this product. Evidence of insurability may be required. A new policy / certificate will be issued to replace the existing policy.
- **Change to Existing Coverage:** If you currently have insurance coverage with Unum and would like to make any changes to your coverage. Including, but not inclusive, to addition or deletion of benefits.
- **Rehire:** If your employment with this group ends and you are rehired.

SECTION 1: Employee Information
Fully complete this section making sure you have answered any and all questions completely and accurately. Information pertaining to your employer name and address (Group number and Eligibility Class, if known) as well as your personal information must be provided.

SECTION 2: Spouse Information
If applying for dependent coverage, fully complete this section making sure you have answered any and all questions completely and accurately.

SECTION 3: Coverage Information
Based on your Plan Highlights (Highlight sheet), choose the amount of coverage you desire (Employee).

Select only one family coverage option for Group Accident.

If your plan includes the option for Hospital Confinement due to Covered Sickness and you wish to elect this Benefit, check Hospital Confinement due to Covered Sickness Benefit under “Optional Employee selected benefits.”

If you require assistance to complete this section, please contact your Plan Administrator.

SECTION 4: Medical Profile
If applying for the Hospital Confinement due to Covered Sickness Benefit, answer the health questions in Section 4.

SECTION 5: Employee (Applicant) Statements
You are required to complete this section. This application cannot be processed if you fail to sign and date the application.

NOTE:
If there are unanswered questions or missing information on the application, it may delay consideration of your application for insurance.

APPLICATION FOR
GROUP ACCIDENT INSURANCE
Evidence of Insurability

Unum Life Insurance Company of America ("Unum")
2211 Congress Street • Portland, Maine 04122

Application Type: ☐ Newly Eligible ☐ Late Applicant ☐ Replace Existing Unum Coverage
☐ Change to Existing Coverage ☐ Rehire

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
Email Address		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		
State	Zip Code	Work Phone #
Are you currently working with the Employer listed on this application? ☐ Yes ☐ No		Scheduled Number of Work Hours/week
Primary beneficiary		Relationship
Contingent beneficiary		Relationship

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage. Any reference to Spouse also applies to Registered Domestic Partner.

Name (First, Middle, Last)		Social Security Number
Gender ☐ F ☐ M	Does the Spouse live in the U.S.? ☐ Yes ☐ No	Date of Birth (mm/dd/yyyy)
Primary beneficiary		Relationship
Contingent beneficiary		Relationship

SECTION 3 Coverage Information

Group Accident ☐ Employee (only) ☐ Employee, Spouse ☐ Employee, Dependent Child(ren) ☐ Employee, Spouse and Dependent Child(ren)	**Cost per pay period** $_____
Employer selected benefit ☐ Wellness	$_____
Optional Employee selected benefit ☐ Hospital Confinement due to Covered Sickness $_____	$_____
Total Cost Per Pay Period	$_____

Employee Name: _____ (Applicant)

Employee SSN: _____ (Applicant)

SECTION 4: Complete if applying for the Hospital Confinement due to Covered Sickness Benefit

	Employee (Applicant)	Spouse
1. Current height and weight	___ ft. ___ in. ____ lbs.	___ ft. ___ in. ____ lbs.
2. Have you (applicant) or your spouse (if applying) been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?..... **Note: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months, have you or your spouse (if applying) been diagnosed with or received treatment by a medical professional for:	☐ Yes ☐ No	☐ Yes ☐ No

- Insulin-dependent diabetes
- Atrial Fibrillation, Angina, Heart Attack, Stroke, Coronary Artery disease, Heart Surgery, Congestive Heart Failure or Cardiomyopathy
- Cirrhosis of the liver or Hepatitis B & C
- High blood pressure treated with 3 or more medications
- Chronic Obstructive Pulmonary disease (COPD) or Emphysema
- Kidney disease (excluding kidney stones)or failure
- Cancer or Malignancy of any kind including Leukemia, Hodgkin's disease or Melanoma (excluding Basal or Squamous Cell carcinoma).

SECTION 5: Employee (Applicant) Statements

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete to the best of my knowledge and belief, and have been given to obtain insurance.

CAUTION: Unum will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, Unum may deny benefits or rescind insurance. **For your protection California law requires the following to appear in this form: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.**

Employee (Applicant) Signature	Date (mm/dd/yyyy)

INSTRUCTIONS
Complete the information below only if you or any person proposed for coverage on the preceding application is currently eligible for Medicare. To be eligible for Medicare, you must be either: (1) age 65 or older; or (2) disabled.

Medicare Certification Form
This is to certify that I have received the "Guide to Health Insurance for People with Medicare" and the "Important Notice to Persons on Medicare".

Employee (Applicant) Signature	Date (mm/dd/yyyy)