APPLICATION FOR
GROUP CRITICAL ILLNESS 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

THIS IS A LIMITED BENEFIT CERTIFICATE.
YOU SHOULD HAVE COMPREHENSIVE HEALTH COVERAGE BEFORE PURCHASING THIS CERTIFICATE.

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

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)

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

SECTION 3: Coverage Information – Complete for Employee (Applicant) and for Spouse (if applicable)

	Employee (Applicant)	Spouse
1. Have you or your spouse (if applying) used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Does any person applying for coverage have comprehensive health benefits from an insurance policy or HMO plan? If "No," you are not eligible for this coverage.	☐ Yes ☐ No	☐ Yes ☐ No
3. Will coverage applied for replace or modify any existing Unum insurance coverage?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," provide details below:

Insured's Name	Policy Number

4. Coverage Type	Coverage Amount	Cost Per Pay Period
a. ☐ Group Critical Illness Insurance ☐ Critical Illness or ☐ Critical Illness with Cancer	Employee $ _____ Spouse $ _____	Employee $ _____ Spouse $ _____
b. ☐ Wellness Benefit		$ _____
Total Cost Per Pay Period		$ _____

SECTION 4: Tier I Medical Profile – Complete as required for all underwritten coverage

	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)?	☐ Yes ☐ No	☐ Yes ☐ No
Note: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
3. In the past 10 years, have you or your spouse (if applying) been diagnosed with or received treatment, including medication, by a medical professional, or been hospitalized for any of the following:	☐ Yes ☐ No	☐ Yes ☐ No
– Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure or cardiomyopathy – Chronic Obstructive Pulmonary Disease (COPD) or emphysema – Cirrhosis of the liver or Hepatitis B or C – Diabetes (except gestational or diet controlled) – Glaucoma, retinitis pigmentosa or macular degeneration – High blood pressure treated with 3 or more medications – Kidney disease (excluding kidney stones) or failure – Major organ failure (liver, heart, lung or pancreas) – Stroke/Transient Ischemic Attack (TIA)		
4. Respond only if applying for cancer coverage: In the past 10 years, have you or your spouse (if applying) been diagnosed with or received treatment, including medication, by a medical professional, or been hospitalized for cancer or malignancy of any kind (including carcinoma in situ and melanoma), excluding basal and squamous cell carcinoma?	☐ Yes ☐ No	☐ Yes ☐ No

Employee Name: _____ (Applicant)

Employee SSN: _____ (Applicant)

SECTION 5: Tier II Medical Profile – Complete if additional underwriting is required

Employee (Applicant)

1. To the best of your knowledge and belief, have any two of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:

   a. Heart attack or disease, stroke, kidney disease or diabetes..... ☐ Yes ☐ No

   b. Respond only if applying for cancer coverage:
      – Cancer (excluding basal cell carcinoma and squamous cell carcinoma) ..... ☐ Yes ☐ No

2. Have you ever been diagnosed with or received treatment, including medication, by a medical professional, or been hospitalized for any of the following:

   a. – Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic lung disease
      – Cirrhosis of the liver or Hepatitis B or C
      – Diabetes (except gestational)
      – Heart attack, coronary artery disease, angina, or surgery on the heart or heart valve(s)
      – Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)
      – Major organ failure (liver, heart, lung or pancreas)
      – Peripheral vascular disease
      – Stroke/Transient Ischemic Attack (TIA) ..... ☐ Yes ☐ No

   b. Respond only if applying for cancer coverage:
      – Cancer (excluding basal cell carcinoma and squamous cell carcinoma) ..... ☐ Yes ☐ No

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

SECTION 6: 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).

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

All statements and answers provided on this application are true and complete to the best of my knowledge and belief, and are 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)