GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE
EVIDENCE OF INSURABILITY

Instructions for Application

IMPORTANT: PLEASE FILL OUT ALL SECTIONS FULLY AND COMPLETELY BASED ON THE INSTRUCTIONS BELOW.
If there are unanswered questions or missing information on the application, it may delay consideration of your application for insurance.

Instructions for Application

Definition of Application Type: Check the applicable application type:

- **Newly Eligible:** Application for insurance on a newly eligible or newly hired employee, usually a new employee applying for this coverage.
- **Change to Existing Coverage:** Application for insurance for requested changes to an existing Unum policy.
- **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
- **Late Applicant:** Application for insurance for a previously eligible employee. An individual is considered to be a late applicant if working for the employer in an eligible group and the period within which coverage could first be applied for without Evidence of Insurability has passed.
- **Rehire:** If employment ends with this group and you are rehired.

Section 1: Employee Information
Fully complete this section making certain to answer any and all questions completely and accurately. Information regarding your employer's name and address, as well as your personal information must be provided. (See your Plan Administrator if further information is needed.)

Section 2: Spouse Information
Complete this information if applying for Spouse coverage. Fully complete this section making certain to answer any and all questions completely and accurately.

Section 3: Coverage Information
Make no more than one selection. If assistance is required for completion, please contact your Plan Administrator.

Section 4: Medical Profile
Complete as required for all underwritten coverage.

Section 5: Employee (Applicant) Statements
This section is required to be completed. This application cannot be processed if you fail to sign and date the application.

APPLICATION FOR GROUP HOSPITAL CONFINEMENT INDEMNITY 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		Date of Hire (mm/dd/yyyy)
Street/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)

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

☐ Employee (only) ☐ Employee & Spouse ☐ Employee & Dependent Child(ren) ☐ Employee, Spouse, & Dependent Child(ren)

	Employee (Applicant)	**Spouse**
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
Total Cost per Pay Period	$

Employee Name: _____ Employee SSN: _____

SECTION 4: 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)? ..... **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 3 years, have you (applicant) or your spouse (if applying) been diagnosed with or received treatment by a medical professional for:	☐ Yes ☐ No	☐ Yes ☐ No

- Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure, cardiomyopathy, or heart valve disease
- Stroke/transient ischemic attack (TIA), aneurysm
- Vascular disease excluding varicose veins
- Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis (excluding asthma)
- Cirrhosis of the liver, hepatitis (other than A)
- Diabetes (other than gestational or diet controlled)
- Alcohol or drug usage
- High blood pressure with a systolic reading (top number) greater than 166 or a diastolic reading (lower number) greater than 100
- Kidney disease or failure (excluding kidney stones)
- Musculoskeletal disease not related to an accidental injury (excluding carpal tunnel syndrome or osteoarthritis)
- Neurological disease excluding headache or epilepsy if no seizure in the last 3 years
- Schizophrenia, psychosis, major depressive disorder, bipolar disorder or post traumatic stress disorder
- Cancer or malignancy of any kind including leukemia, Hodgkin's disease or skin cancer (excluding basal cell or squamous cell carcinoma of the skin)

Employee Name: _____ Employee SSN: _____

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.**

IMPORTANT: If you do not have comprehensive health coverage you are not eligible for this coverage. I understand that this is a Group Hospital Confinement Indemnity policy and that it does not provide coverage for and is not intended to replace comprehensive health benefits from an insurance policy, an HMO plan or an employer health benefit plan. I acknowledge that I have comprehensive hospital, surgical, or medical coverage.

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)