Statement of Insurability
Instructions

1. **Employer's Name, Group #, Location/Division/Sub Group #, Class # (if applicable)**
   To be prefilled by your Employer. Any questions or concerns, please contact your Benefits Administrator.

2. **Employee & Dependent Information:**
   Please complete information in full for individuals requesting coverage i.e.; employee, spouse, children. If not requesting coverage, please leave blank.

3. **Products being Underwritten:** This section must be completed in order to process the request for coverage. This section refers to the type(s) and amount(s) of coverage you (and your dependents, if applicable) already have with your employer and any additional amounts you are requesting at this time. There is a space for each benefit type – Basic Life, Supplemental Life, STD and LTD – you may disregard any of the benefits that you are not applying for, they are not applicable.

   Amount You Already Have with Employer – Complete this column if you have some level of coverage already in place with your employer's benefit plan. If you have no current coverage, just enter "0" in this column.

   Amount You're Requesting – Complete this column if you are new to this benefit coverage OR if you are requesting an additional amount of coverage above current coverage. Only include the amount above current coverage in this column if that applies to you.

   - Your Benefits Administrator may complete this section of the form for you. If he/she does, make sure to complete the check box for the reason form is being submitted at the end of the section.
   - If your Benefits Administrator does not complete this section for you, you will need to complete it.

   If you have any questions or concerns regarding the type(s) or amount(s) of coverage you already have with your employer or that you're requesting at this time, please contact your Benefits Administrator prior to submitting your request for coverage. If this information is missing or incomplete it will delay your request for coverage.

4. **Completing personal information on the form.** All questions must be answered for each individual applying for coverage. All health questions answered yes must include details of the individual's medical history where asked. If this information is missing or incomplete, the application may be returned to you for completion.

5. **Signature(s) and date(s).** The signature and sign date of both employee, and spouse if applicable, must be completed on the bottom of the Statement of Insurability form where specified. Forms with this information missing will be returned, which will delay your request for coverage.

6. **For your records.** Please make a copy of the completed form for your records. The Insurance Information Practices Notice should be reviewed and kept by you for your records.

7. **IMPORTANT! Submitting the form.** After completing, signing and dating the Statement of Insurability form, please mail, fax or email the Statement of Insurability Form directly to the insurance company, please see below:

   UnitedHealthcare
   Group Medical Underwriting Services
   P.O. Box 17829
   Portland, ME 04112

   Fax #: 1-855-290-5224
   Email: eoi_underwriting@uhc.com

UnitedHealthcare Insurance Company
Statement of Insurability

Employer Name		
Group #	Location/Division/Sub Group #	Class #
Employee Name	Employee Social Security #.	
Employee Home Address	City, State, Zip	
Date of Birth / Date of Hire	Home Phone #	Work Phone #

Income
☐ Salaried Annual base salary _____ ☐ Hourly Hourly rate _____ # of hours worked _____ per week

Persons Proposed for Coverage (list Employee Information first):

EMPLOYEE INFORMATION	SEX (M/F)	HEIGHT (FT, IN)	WEIGHT (LBS)

SPOUSE INFORMATION NAME (FIRST, M.I., LAST)	SPOUSE SOCIAL SECURITY #	BIRTH DATE (MM/DD/YY)	SEX (M/F)	HEIGHT (FT, IN)	WEIGHT (LBS)

DEPENDENT CHILD INFORMATION NAME (FIRST, M.I., LAST)	BIRTH DATE (MM/DD/YY)	SEX (M/F)	HEIGHT (FT, IN)	WEIGHT (LBS)

Product(s) Being Underwritten

EMPLOYEE COVERAGE	AMOUNT YOU ALREADY HAVE WITH EMPLOYER	AMOUNT YOU'RE REQUESTING (If increase, only include additional amount)	TOTAL AMOUNT OF CURRENT COVERAGE PLUS NEW REQUEST
Basic Life	$	$	$
Supplemental Life	$	$	$
Short Term Disability	$_____ % of Income _____	$_____ % of Income _____	$_____ % of Income _____
Long Term Disability	$_____ % of Income _____	$_____ % of Income _____	$_____ % of Income _____

SPOUSE COVERAGE	AMOUNT YOU ALREADY HAVE WITH EMPLOYER	AMOUNT YOU'RE REQUESTING (If increase, only include additional amount)	TOTAL AMOUNT OF CURRENT COVERAGE PLUS NEW REQUEST
Basic Life	$	$	$
Supplemental Life	$	$	$

DEPENDENT CHILD COVERAGE	AMOUNT YOU ALREADY HAVE WITH EMPLOYER	AMOUNT YOU'RE REQUESTING (If increase, only include additional amount)	TOTAL AMOUNT OF CURRENT COVERAGE PLUS NEW REQUEST
Basic Life	$	$	$
Supplemental Life	$	$	$

This Statement of Insurability is being submitted due to: ☐ Initial Enrollment ☐ Late Entrant ☐ Employer Open Enrollment
☐ Increase ☐ Other. If other, please explain: _____

The following questions apply to all persons proposed for coverage:

1. Within the past 7 years has any person proposed for coverage ever been medically treated or medically diagnosed with:
   a) ☐ Yes ☐ No Diabetes or sugar, albumin or blood in the urine: If Yes, when first diagnosed? _____ (if within the past 7 years)
   b) ☐ Yes ☐ No High blood pressure, chest pain, heart murmur, shortness of breath, angina or other heart or circulatory disorder?
   c) ☐ Yes ☐ No Stroke, epilepsy, fainting, dizziness, headaches or any disorder of the brain or nervous system?
   d) ☐ Yes ☐ No Tuberculosis, asthma, hay fever, lung or respiratory disorder?
   e) ☐ Yes ☐ No Stomach or duodenal ulcer, other ulcer, colitis, disorder of gall bladder, liver, stomach or intestines?
   f) ☐ Yes ☐ No Varicose veins, varicose ulcers, or phlebitis or hernia of any kind?
   g) ☐ Yes ☐ No Kidney, bladder or prostate disorder or other urinary disorder?
   h) ☐ Yes ☐ No Tumor or disease or dysfunction of the breast, reproductive organs or abnormal menstrual period?
   i) ☐ Yes ☐ No Arthritis, rheumatism or any disorder of the joints, muscles, back or bones?
   j) ☐ Yes ☐ No Cancer or tumor or ulcer of any kind, growth or cyst?
   k) ☐ Yes ☐ No Any disorder of eyes, ears, nose or throat?
   l) ☐ Yes ☐ No Alcoholism, narcotic addiction?
   m) ☐ Yes ☐ No Nervous or mental disorder (including professional counseling)?
   n) ☐ Yes ☐ No Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?
2. Within the past 7 years, has any person proposed for coverage:
   a) ☐ Yes ☐ No Had any life or health insurance declined (not applicable to Missouri residents), postponed or modified, or had a waiver or extra premium added?
   b) ☐ Yes ☐ No Been released from the military for medical reasons?
   c) ☐ Yes ☐ No Received payment for disability, illness or injury?
   d) ☐ Yes ☐ No Had a change of weight of more than 10 pounds in the last 12 months? If Yes, state name of person(s), reason(s) and amount(s) of gain/loss in Detail Section below.
3. Within the past 5 years, has any person proposed for coverage:
   a) ☐ Yes ☐ No Had abnormal findings of a physical examination, electrocardiogram, X-ray, blood test or diagnostic test?
   b) ☐ Yes ☐ No Had inpatient or outpatient surgery?
   c) ☐ Yes ☐ No Been advised by a medical professional to have surgery not yet done?
   d) ☐ Yes ☐ No Had any medical treatment for a health or physical impairment, condition or congenital anomaly not mentioned above?
4. ☐ Yes ☐ No Have medications been prescribed to any person proposed for coverage for any reason in the last 12 months? If Yes, please list medication name, dose, dates used and condition used for in Detail Section below.
5. ☐ Yes ☐ No Are any persons to be covered pregnant?
   If Yes: Name of person_____ Expected delivery date:_____

DETAIL SECTION - GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 1 – 4 ABOVE IF MORE SPACE IS NEEDED, ATTACH A SEPARATE PIECE OF PAPER, SIGNED AND DATED.

QUESTION #	NAME OF PERSON FOR WHOM YOU ANSWERED "YES"	REASON / CONDITION	DATE OF ONSET	DIAGNOSIS	NAME, COMPLETE ADDRESS & PHONE # OF MEDICAL PROVIDER	DATE LAST SEEN

NAME, ADDRESS AND PHONE # OF PRIMARY CARE PHYSICIAN OF PERSONS PROPOSED FOR COVERAGE: (if visited within the past 7 years)

	EMPLOYEE	SPOUSE	CHILDREN
DOCTOR NAME			
STREET ADDRESS			
CITY, STATE, ZIP			
PHONE NUMBER			
DATE LAST SEEN			

AUTHORIZATION AND ACKNOWLEDGEMENT

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health or that of my Dependents, to disclose the information to: the UnitedHealthcare Insurance Company; and, its affiliates ("UnitedHealthcare"). This information will be used to determine my eligibility for benefits.

I authorize UnitedHealthcare to: obtain; use; and disclose; my [and my Dependent's] medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize UnitedHealthcare to disclose the information to the Policy's administrator; or as may be required by law. I authorize UnitedHealthcare, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying UnitedHealthcare in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right UnitedHealthcare has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires 24 months after the date it is signed. I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

I request the indicated group coverage for myself and, if applicable, for my dependents. I have not given the agent; or, any other persons any health information not included on this form. I understand that UnitedHealthcare is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; this completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that, subject to the Deferred Effective Date provisions, coverage will not take effect until UnitedHealthcare grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with this application.

NOTICE: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature _____ Date _____

Spouse Signature (if applying for coverage)_____ Date: _____

Return form to: UnitedHealthcare Insurance Company, Medical Underwriting Services, PO Box 17829, Portland, ME 04112

UnitedHealthcare Insurance Company
Insurance Information Practices Notice

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Statement of Insurability Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Statement of Insurability Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with UnitedHealthcare Insurance Company or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. UnitedHealthcare Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

UnitedHealthcare Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.