Evidence of Good Health Application

Evidence of Good Health Application

Group Plans

Purpose

Use this *Group Plans Evidence of Good Health Application*:

- When an employee is requesting coverage.
- When an employee is requesting Employee or Spouse Optional Term Life coverage.

Employer

- Complete Section A.
- This form must be typed or completed in blue or black ink. (Do not use red ink or pencil.)
- Assist your employee in completing Sections B and C, if needed.
- Give the application and a return envelope to your employee.
- Instruct him or her to complete Sections D–F and return the completed application to GSFR®.

Employee

- Complete Sections B–F.
- This form must be typed or completed in blue or black ink. (Do not use red ink or pencil.)
- Date and initial any changes.
- Answer all medical questions.
- Make a copy of the completed form for your records.

Eligibility Requirements

In order to apply for GSFR's products, you must be considered an "eligible employee" or "eligible dependent." **You**

are considered an "eligible employee" if:

- You are defined by your employer as a full-time employee, and
- You work 30 or more hours per week and
- You are paid for your work.

To maintain eligibility you must continue to meet the above requirements. Failure to do so could render you ineligible for GSFR's products. After completing this form you may email it to: *BenefitsHelp@Proton.me*.

Reset Form

SECTION A — EMPLOYER INFORMATION (EMPLOYER COMPLETE THIS SECTION)

Employer name: T Org

Daytime telephone: (630) 614-4796 Fax number: _____

Employer number: 71061 (International)

Employer address: PO Box 969

City: Wheaton State: IL ZIP Code: 60187-0969

Email address: BenefitsHelp@Proton.me

Employee classification: Select One

☐ I confirm this employee is actively working.

Employer's authorized representative: _____ Date: _____

SECTION B — EMPLOYEE INFORMATION (EMPLOYEE COMPLETE THIS SECTION)

Employee first name: _____ MI: _____ Last name: _____

Social Security number: _____ Birth date: _____ Home telephone number: _____

Email address: _____

Employee address: _____

City: _____ State: _____ ZIP Code: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married

SECTION C — COVERAGE OPTIONS (EMPLOYEE COMPLETE THIS SECTION)

Unum Non-Restricted Countries

Please select the coverage(s) for which you are applying:

Employee - Employer Paid Term Life (basic): $10,000

Employee Total Term life in force (Employer paid and current optional life in force): $ _____

Employee Optional Term Life Plan

Optional Term Life applying for $_____

Optional Term Life currently in force: $_____

Total Employee Term Life and Optional Term Life amount requested: $_____

Please select the coverage(s) for which you are applying:

Affiliated Spouse - Employer Paid Term Life Plan (basic) $10,000

Affiliated Spouse Term Life currently in force (Employer paid and current optional life in force): $ _____

Affiliated Spouse Optional Term Life Plan

Optional Term Life applying for: $ _____

Optional Term Life currently in force: $_____

Total Afflicated Spouse Term Life and Optional Term Life amount requested: $_____

Employee or Affliated Spouse Term Life Plan (basic) amount and Optional Term Life combined amount cannot exceed $750,000.

Non-Affiliated Spouse Optional Term Life Plan

Spouse Optional Term Life currently in force: $_____

Spouse Optional Term Life applying for: $_____

Total Spouse Optional Term Life amount requested: $_____

Must be in $5,000 increments. The Spouse Optional Term Life Plan amount cannot exceed 50% of employee's total life coverage up to a maximum of $250,000.

Unum Restricted Countries

Non-Affiliated Spouse Optional Term Life Plan

Spouse Optional Term Life in force: $_____

Spouse Optional Term Life applying for: $_____

Total Spouse Term Life and Spouse Optional Term Life amount requested: $_____

Must be in $5,000 increments. The Spouse Optional Term Life Plan amount cannot exceed 50% of employee's total life coverage.

ABOUT OUR PLANS

Case Professional Resources, LLC provides individual applicant underwriting for the term life and disability plans.

Unum Life Insurance Company of America and its duly authorized representatives insure and provide claims processing services for the term life, accident and disability plans.

SECTION D — APPLICANT AND SPOUSE INFORMATION

Please complete this section for yourself and each person for whom you are requesting coverage.

First name (employee): _____ MI: _____ Last: _____

Social Security number: _____ Birth date: _____ Place of birth (country): _____

Gender: ☐ Male ☐ Female Relationship: Applicant Height: _____ Weight: _____

First name (spouse): _____ MI: _____ Last: _____

Social Security number: _____ Birth date: _____ Place of birth (country): _____

Gender: ☐ Male ☐ Female Relationship: Spouse Height: _____ Weight: _____

SECTION E — APPLICANT AND SPOUSE MEDICAL INFORMATION

You must answer all medical questions. Failure to answer all questions thoroughly will result in return of the application to you for completion.

Have you or any applicant ever applied and been rejected for any:

1. Medical policies ☐ Yes ☐ No

Name of person: _____ Reason: _____

Name of person: _____ Reason: _____

2. Life insurance policies ☐ Yes ☐ No

Name of person: _____ Reason: _____

Name of person: _____ Reason: _____

Part I.

Please answer each question completely. If it is found that you have supplied materially incorrect or misleading enrollment eligibility information, or if it is proven that you have supplied fraudulent statements or fraudulent omissions, your subscription agreement may be voided.

1. Do you — or any family member applying — use any medical equipment (such as a walker, wheelchair, cane or hospital bed)? ☐ Yes ☐ No

2. Are you — or any family member applying — currently receiving home health care? ☐ Yes ☐ No

3. If you answered "Yes" to question 1 or 2, please provide the name(s) of the affected person(s) and specifics about the condition:

Name of person: _____ Condition/reason: _____

Name of person: _____ Condition/reason: _____

4. Give date of last menstrual period for each female family member applying:

Name of person: _____ Date of last period: _____

5. Are you — or any family member applying — currently pregnant? ☐ Yes ☐ No

Name of pregnant person: _____ Date medically diagnosed or treated: _____

6. Have you — or any family member applying — gained or lost more than 20 pounds over the past 3 months?

☐ Yes ☐ No If "Yes" provide the person's name and amount gained or lost:

Name of person: _____ Weight gained/lost: _____

Name of person: _____ Weight gained/lost: _____

Part II.

Please indicate by checking the appropriate block(s) below if you — or any family member applying — have been treated by, diagnosed by or received medical advice from a physician or other health care provider for any condition, illness, injury or surgery listed below **within the last five years.**

List dependents by name:

Spouse _____

Under dependents applying for coverage, mark each condition below as appropriate.

Conditions	Employee	Spouse
7. AIDS or positive test for HIV, HTLV-III/LAV antibodies (Leave this question blank if you have tested positive for HIV but have not developed symptoms of the disease AIDS.)	☐	☐
8. Alcoholism	☐	☐
9. Alzheimer's disease	☐	☐
10. Amputation of limb. **Specify:** _____	☐	☐
11. Arteriovenous Malformation (AVM)	☐	☐
12. Arthritis	☐	☐
13. Other joint diseases.* **Specify:** _____	☐	☐
14. Asthma	☐	☐
15. Back disabilities*	☐	☐
16. Back pain — chronic*	☐	☐
17. Brain tumor	☐	☐
18. Cancer	☐	☐
19. Cataract(s) **Right:** _____ **Left:** _____	☐	☐
20. Chest pain or angina	☐	☐
21. Chiropractic visits. **Specify number of visits:** _____	☐	☐
22. Cholesterol. **Specify current reading:** _____	☐	☐
23. Cirrhosis	☐	☐
24. Other liver disease. **Specify:** _____	☐	☐
25. Congenital anomalies and conditions. **Specify:** _____	☐	☐
26. Dementia, "senility" or increasing forgetfulness with age	☐	☐
27. Diabetes — controlled with diet **Specify current fasting blood sugar:** _____	☐	☐
28. Diabetes — controlled with medication	☐	☐
29. Drug dependency	☐	☐
30. Ear conditions (including frequent ear infections) **Specify:** _____	☐	☐
31. Emphysema	☐	☐
32. Other lung disease (including work related, for example, "black lung") **Specify:** _____	☐	☐
33. Gynecological. **Specify:** _____ If recent delivery, please provide date of medical release (postpartum checkup) from obstetrician/gynecologist Date: _____	☐	☐

* If you check this condition, you must list under Part III or on a separate piece of paper the name(s) of the attending physician, osteopath or chiropractor and date(s) of treatment for each family member.

Conditions	Employee	Spouse
34. Heart attack	☐	☐
35. Other heart disease	☐	☐
36. Hepatitis	☐	☐
37. High blood pressure (if checked, indicate usual blood pressure) **Specify:** _____	☐	☐
38. Infertility. **Specify:** _____	☐	☐
39. Immunization for children Name and address of pediatrician: _____ _____ _____	☐	☐
40. Kidney/renal failure	☐	☐
41. Other kidney disorder. **Specify:** _____	☐	☐
42. Leukemia	☐	☐
43. Other hematologic (blood) disorder. **Specify:** _____	☐	☐
44. Musculoskeletal (pertaining to muscle or bone) injury or illness **Specify:** _____	☐	☐
45. Neurological deficit or disorder, including head or spinal injury or paralysis. **Specify:** _____	☐	☐
46. Psychiatric disorder/behavioral health. **Specify:** _____	☐	☐
47. Severe injury or burns. **Specify:** _____	☐	☐
48. Severe visual impairment/blindness	☐	☐
49. Spinal injuries	☐	☐
50. Stroke	☐	☐
51. Surgery of any kind. **Specify:** _____	☐	☐
52. Temporomandibular Joint Syndrome (TMJ)	☐	☐
53. Transient Ischemic Attacks (TIAs)	☐	☐
54. Urological	☐	☐
55. Any other conditions, injuries or ailments not specifically mentioned above for which you have been treated by, diagnosed by or received medical advice from a physician or other health care provider within the last five (5) years?	**Please explain:** _____ _____ _____	
56. I have reviewed the list of conditions and none applies for:	☐	☐

Part III.

Please provide details of the condition and use additional paper if necessary.

Patient's name/diagnosis
Type of treatment/surgery | **Hospital treatment?** | **Attending physician** | **Dates of illness**

Patient Name _____ ☐ Inpatient Name: _____ From: _____

Diagnosis _____ ☐ Outpatient Address: _____ To: _____

Type of Treatment/Surgery _____ Date: _____ Telephone: _____

Hospital name: _____

Patient Name _____ ☐ Inpatient Name: _____ From: _____

Diagnosis _____ ☐ Outpatient Address: _____ To: _____

Type of Treatment/Surgery _____ Date: _____ Telephone: _____

Hospital name: _____

Patient Name _____ ☐ Inpatient Name: _____ From: _____

Diagnosis _____ ☐ Outpatient Address: _____ To: _____

Type of Treatment/Surgery _____ Date: _____ Telephone: _____

Hospital name: _____

When was the last time each person applying for coverage visited a doctor (other than in an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary.

Name of person	Date of exam	Full name, address, and telephone numbers of providers	Reason
Employee:			
Spouse:			

When was the last time each person applying for coverage visited an emergency room at a hospital or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

Name of person	Date of exam	Full name, address, and telephone numbers of doctors and hospitals	Reason
Employee:			
Spouse:			

Part IV.

Prescription Drug Use

If you — or any family members applying — have taken prescribed drugs within the last year, please list drugs taken and reason:

Name of person		Medication/dosage	Condition/reason	Dates of use
_____	☐ N/A	_____	_____	From: _____ To: _____
_____	☐ N/A	_____	_____	From: _____ To: _____
_____	☐ N/A	_____	_____	From: _____ To: _____
_____	☐ N/A	_____	_____	From: _____ To: _____

Alcohol Use

If you — or any family members applying — drink alcoholic beverages, please indicate frequency of use:

Name of person	Number of drinks per week (Serving size per drink equals 1 1/2 oz. liquor, 12 oz. beer, 5 oz. wine)
_____	_____
_____	_____
_____	_____

Tobacco Use

If you — or any family members applying — have ever smoked, please indicate the amount of cigarettes, cigars, pipes or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use:

Name of person	Amount per day/type	Dates of use
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____

SECTION F — APPLICANT AND DEPENDENT AUTHORIZATIONS

Please read this information carefully. Make a copy of the entire application and retain it for your records.

Unum Life Insurance Company of America (Unum) and its duly authorized representatives
Case Professional Resources, LLC

GSRF®

When your request for coverage is evaluated by any of the above companies, they need to ask you questions about the health and medical history of each person for whom you request coverage. In addition, you are also requested to authorize any physician or hospital to provide each of these companies with reports, if necessary, about the health of each person. In some instances each company may require a physical examination or other tests.

Caution: If your answers on this application are incorrect or untrue, Unum and its duly authorized representatives, Case Professional Resources, LLC,

or GSFR may deny benefits or rescind your insurance or other coverage, limited to the contestability period. Any person who, knowingly or with intent to defraud or deceive GSFR or any insurance company, submits an application for insurance or other coverages containing any materially false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy or other coverages for which evidence of insurability or good health is required. I have read and understand the statements above and understand I am entitled to a copy.

Print name of applicant (employee):_____

Signature (employee): _____ **Social Security number:** _____ **Date:** _____

Signature of spouse: _____ **Social Security number:** _____ **Date:** _____
(if to be covered for life)

This application is not complete unless the authorization on the next page is signed by the applicant and dependents over 18 applying for coverage.

AUTHORIZATION

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or medically related facility or service, insurance company, insurance service provider, third-party administrator, producer and employer that has information about my health, employment or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications and perform administration functions for Unum Life Insurance Company of America and its duly authorized representatives, Case Professional Resources, LLC, and GSRF (collectively referred to as "Recipients"). Information about my health may relate to any disorder of the immune system, including HIV, use of drugs and alcohol, mental and physical history, condition, advice or treatment, but does not include psychotherapy notes. This authorization excludes divulging whether a test for HIV has been conducted and the results of such test. Such test will not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that an applicant has AIDS/ARC.

I understand that any information Recipients obtain pursuant to this authorization will be used for evaluating and processing my application for coverage and performing plan administration functions. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Recipients have relied on the authorization prior to notice of revocation or have a legal right to contest a claim under the policy or the policy itself. I understand that if I revoke this authorization, Recipients may not be able to evaluate or process my application, and this may be the basis for denying my application. I may revoke this authorization by sending written notice to HIPAA Privacy Contact, GSFR, 5005 LBJ Freeway, Ste. 2200, Dallas, TX 75244-6152.

I understand if I do not sign this authorization or if I alter its content in any way, Recipients may not be able to evaluate or process my application, and this may be the basis for denying my application.

Print name of applicant (employee): _____

Signature (employee): _____ **Social Security number:** _____ **Date:** _____

Signature of spouse: _____ **Social Security number:** _____ **Date:** _____
(if to be covered for life)

Information about the individual's personal or legal representative, if applicable:

Name: _____ **Relationship:** _____

If signing on behalf of another, please include the proper documentation that attests to your ability to sign (death certificate, court-stamped *Letters of Appointment of the Executor of Estate*, proof of custody, power of attorney, etc.).