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

APPLICATION FOR
GROUP CRITICAL ILLNESS INSURANCE
Evidence of Insurability

Application Type: ☐ New Enrollee ☐ Change to Existing Coverage ☐ Reinstatement
☐ Internal Replacement ☐ Late Applicant ☐ Rehire

THIS IS A LIMITED BENEFIT CERTIFICATE.

YOU SHOULD HAVE COMPREHENSIVE HEALTH COVERAGE BEFORE PURCHASING THIS CERTFICIATE.

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 #
Are you Actively at Work? ☐ Yes ☐ No		Employee ID/Payroll #
a. Are you a U.S. Citizen or Canadian Citizen working in the U.S.? ☐ Yes ☐ No (If "No" reply to part b)		b. Are you legally authorized to work in the U.S.? ☐ Yes ☐ No
Employer Name	Group Number	Date of Hire (mm/dd/yyyy)
Occupation		Eligibility Class
Scheduled Number of Work Hours per Week		Work Phone #

SECTION 2: Spouse Information – Complete Only if applying for Spouse coverage

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

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

SECTION 3: Coverage Information – Complete question 1 and 2 for Employee (Applicant) and for Spouse

	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.		
3.		

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Coverage Plans:	Coverage Amount	Premium
☐ Critical Illness	☐ Employee $ _____ ☐ Spouse $ _____	☐ Employee $ _____ ☐ Spouse $ _____
☐ Critical Illness ☐ Critical Illness with Cancer	☐ Employee $ _____ ☐ Spouse $ _____	☐ Employee $ _____ ☐ Spouse $ _____
☐ Critical Illness ☐ Critical Illness with Cancer Benefit	☐ Employee CI $ _____ ☐ Spouse CI $ _____	☐ Employee CI $ _____ ☐ Spouse CI $ _____ ☐ Cancer Benefit $ _____
☐ Cancer Benefit ☐ Cancer Benefit with Critical Illness	☐ Employee CI $ _____ ☐ Spouse CI $ _____	☐ Cancer Benefit $ _____ ☐ Employee CI $ _____ ☐ Spouse CI $ _____
☐ Cancer Benefit ☐ Employee (only) ☐ Employee and Children ☐ Employee, Spouse and Children		$ _____
☐ Wellness Benefit		$ _____
	Total Payroll Premium per deduction	$ _____
Indicate Tax Status	☐ Pre-Tax or ☐ After Tax	

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

SECTION 4: Tier 1 Medical Profile – Complete as required for all underwritten coverage

	Employee (Applicant)	Spouse
1. Provide height and weight	___ ft. ___ in. ____ lbs.	___ ft. ___ in. ____ lbs.
2. In the past 10 years, have you or your spouse (if applying) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	
3. In the past 10 years, have you or your spouse (if applying) been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	☐ Yes ☐ No	
– Cirrhosis of the liver or hepatitis (excluding hepatitis A) – Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma) – Heart attack, coronary artery disease, atrial fibrillation, congestive heart failure, cardiomyopathy, abnormal heart catheterization, angina, or surgery on the heart or heart valve(s) – Stroke, transient ischemic attack (TIA) or Peripheral Vascular Disease – High blood pressure treated with 3 or more medications – Major organ failure (liver, heart, lung, pancreas) – Diabetes (excluding gestational) – Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma) – Glaucoma, retinitis pigmentosa, macular degeneration or optic neuritis – Neurofibromatosis, Von Hippel Lindau Disease, tuberous sclerosis or benign brain tumor		
4. In the past 10 years, have you or your spouse (if applying) been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind (including carcinoma in situ), excluding basal cell carcinoma?	☐ Yes ☐ No	
5. In the past 10 years, have you or your spouse (if applying) been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind (including carcinoma in situ), excluding basal cell carcinoma or squamous cell carcinoma or Clark's Level I or II melanoma?	☐ Yes ☐ No	
6. Within the past 5 years have you or your spouse (if applying) received medical advice or sought treatment from a member of the medical community for skin cancer including basal cell carcinoma, squamous cell carcinoma or Clark's Level I or II melanoma?	☐ Yes ☐ No	

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

SECTION 5: Tier 2 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
   – Stroke
   – Kidney disease
   – Diabetes ..... ☐ Yes ☐ No

   (b) Respond only if applying for cancer:
   – Cancer (excluding basal cell carcinoma, squamous cell carcinoma and Clark's Level I or II melanoma) ..... ☐ 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. If my Employer pays the full cost of my coverage, the effective date will not be earlier than the first day of the month following the date I become eligible for coverage.

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

I understand that the benefits to be provided under this policy are part of a plan sponsored by my Employer. That plan may provide a number of different benefits or coverages in addition to this one. While I may be required to contribute towards the coverages provided through the plan, my Employer is responsible for paying any difference between the total cost of the plan's benefits and the contributions paid by me and other employees. The total amount my Employer and I are required to contribute may be lower as a result of discounts offered by Unum based on the plan's purchase of multiple Unum coverages which have helped my Employer to provide me with a broader variety of benefit choices.

All statements and answers provided on this application are true and complete 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. Any person who, knowingly and with the intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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

Employee Name: _____ (Applicant)

Employee SSN: _____ (Applicant)

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	Dated (mm/dd/yyyy)