

The University of Texas System

EVIDENCE OF INSURABILITY APPLICATION

Voluntary Group Term Life Insurance (VGTL),
Short Term Disability and/or Long Term Disability

REMEMBER: You must complete each page in full, and the application must be signed and dated on Page 3 to be considered. Please complete this application in black or blue ink. Return this application to:

Dearborn National
Administrative Offices, Attn: Medical Underwriting Dept.
P.O. Box 655403
Dallas, Texas 75265-5403

To be completed by the Employee/Retired Employee:
 New Hire
 Annual Enrollment Change
 Qualified Change of Status Event
(Date of Event _____)

This form cannot be considered unless received by Fort Dearborn Life within 30 days following the end of your initial eligibility period, a qualified change of status event, or if applying during Annual Enrollment within 15 days of the close of Annual Enrollment. Insurance that requires satisfactory evidence of good health will not be effective for an applicant unless, and until, Fort Dearborn Life accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

You are applying for (Check all that apply): Voluntary Group Term Life Short Term Disability Long Term Disability

Section A: EMPLOYEE/RETIRED EMPLOYEE DATA

Check the appropriate UT System Institution from which you are employed or retired:

<input type="checkbox"/> 714 U. T. Arlington	<input type="checkbox"/> 724 U. T. El Paso	<input type="checkbox"/> 750 U. T. Tyler	<input type="checkbox"/> 506 U. T. M.D. Anderson Cancer Ctr Houston
<input type="checkbox"/> 721 U. T. Austin	<input type="checkbox"/> 736 U. T. Pan American	<input type="checkbox"/> 785 U. T. HSC Tyler	<input type="checkbox"/> 723 U. T. Medical Branch Galveston
<input type="checkbox"/> 747 U. T. Brownsville	<input type="checkbox"/> 742 U. T. Permian Basin	<input type="checkbox"/> 744 U. T. HSC Houston	<input type="checkbox"/> 729 U. T. Southwestern Medical Ctr Dallas
<input type="checkbox"/> 738 U. T. Dallas	<input type="checkbox"/> 743 U. T. San Antonio	<input type="checkbox"/> 745 U. T. HSC San Antonio	<input type="checkbox"/> 720 U. T. System Administration Austin

Social Security No. or Benefits ID	<input type="checkbox"/> Employee Name: Last First MI	<input type="checkbox"/> Retired Employee	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM DD YYYY / /	Height Ft. In.	Weight Lbs.
Home Mailing Address-Street	City		State	Zip		
Employee Basic Annual Earnings:	Email Address:					

Section B: REQUESTED COVERAGE

VOLUNTARY GROUP TERM LIFE INSURANCE (VGTL) (Underwritten by Fort Dearborn Life Insurance Company)

Employee VGTL Coverage	Current Coverage Amount \$ _____	<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x Earnings
Employee's Spouse VGTL Coverage	\$ _____	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Retired Employee VGTL Coverage	\$ _____	<input type="checkbox"/> \$7,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Retired Employee's Spouse VGTL Coverage	\$ _____	<input type="checkbox"/> \$3,000

DISABILITY INSURANCE (Employees only) (Underwritten by Fort Dearborn Life Insurance Company)

Short Term Disability Long Term Disability

Section C: SPOUSE DATA to be completed for a spouse applying for the VGTL Insurance

Relationship to Employee or Retired Employee	Name: Last First MI	Social Security No. or Benefits ID	Date of Birth MM / DD / YYYY / /	Height Ft. / In.	Weight Lbs.
<input type="checkbox"/> Spouse			/ /	/	

Employee/Retired Employee Name _____

SSN or Benefits ID _____

Section D: HEALTH INFORMATION (Answer all questions fully and truthfully for any person applying for coverage.)

Has any person applying for coverage been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in the questions below? Check either "Yes" or "No" to each question and circle the specific condition(s) . Details to all "Yes" answers must be provided. Omission of any information may result in an adverse underwriting decision.	Employee or Retired Employee	Spouse
1. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign or malignant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. High blood pressure, heart attack, pain or pressure in the chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the past 5 years, has any person applying for coverage been treated for a mental, emotional or nervous disorder, used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician, been advised by a physician to reduce consumption of alcohol, been treated or convicted in connection with alcohol/ drugs, and/or been told to have counseling for the use of alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is there a current use of prescribed medications or use in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Any surgical operation performed or advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past 5 years, with the exception of a past pregnancy, has any person applying for coverage lost time from work for more than 10 consecutive work days for any physical, mental or emotional condition, disability, injury or sickness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Is any person applying for coverage <u>currently</u> pregnant? If "Yes", indicate anticipated delivery date. Provide details of current/prior complications.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any person applying for coverage ever been declined for insurance or offered a rated or restricted policy, either as a new policy or reinstatement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Within the past 5 years, has any person applying for coverage had symptoms, been diagnosed with, and/or received treatment from a member of the health profession for ANY HEALTH CONDITION other than those conditions listed above in questions 1 through 12?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanation of "Yes" answers in Section D - Please provide details of "Yes" answers below. Please complete Form No. UT-EOI-App-11-Exp 2 for additional explanation/details of "Yes" answers in Section D and please remember to sign and date it.

Q#	Person	Medical Condition	Dates From / To	Hospitalized Yes / No	Surgery Yes / No	Treatment / Medication	Current Medication / Remaining Problems	Names and Addresses of Physicians and Hospitals

Employee/Retired Employee Name _____ SSN or Benefits ID _____

Section E: AGREEMENTS AND AUTHORIZATION – Please read carefully before signing.

I, the undersigned applicant(s), have read and agree that, to the best of my knowledge and belief, the above statements and answers, and all written, telephonic and electronic information I have provided in support of my Application is complete, true and correctly recorded. I agree that they shall be the basis of the issuance of insurance for me and/or my dependents, if applicable, under the Group Policies. Further, I understand that, except where specifically provided in the Group Policies, Fort Dearborn Life Insurance Company (FDL) and/or The University of Texas System shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to the date of approval of my request for insurance. I understand that insurance subject to medical questions requires approval by FDL, and additional medical information, including blood work, may be required to approve such insurance. I also understand that I am responsible to report to FDL's medical underwriting department any change in my health or that of my dependents, if applicable, prior to the date of approval of this Application, and that coverage will not become effective until FDL approves my Application, provided that I am actively at work on that date.

I understand and agree that:

- This authorization is voluntary and that my signature is required in order for FDL to consider ths Application and to make a determination on whether to accept and issue the coverage(s) applied for herein;
- If I refuse to sign this authorization, FDL has the right to deny my request for coverage or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire 24 months from the date it is signed;
- All correspondence regarding coverage for those individuals listed on this Application will be sent to the Employee or Retired Employee.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from FDL.

If my answers on this Application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable, subject to the terms of the contract.

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, HMO, employer, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department, its authorized representative(s) or reinsurers, any information relating to me or my dependents concerning medical history, prescriptions, advice, care, or treatment, including any claims processed by Blue Cross and Blue Shield of Texas (BCBSTX) for any health condition, including but not limited to drug or alcohol use or abuse, mental illness or physical condition, HIV (AIDS Virus) or other sexually transmitted diseases.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

X _____ () _____ () _____
 Signature of Employee/Retired Employee Date Signed Daytime Phone Evening Phone

X _____ () _____ () _____
 Signature of Spouse (if requesting insurance) Date Signed Daytime Phone Evening Phone

Remember: You must complete this application in its entirety to be considered for coverage. Return this application to: Dearborn National ♦ Administrative Offices, Attn: Medical Underwriting Dept. ♦ P.O. Box 655403 ♦ Dallas, Texas 75265-5403

(Please retain with your insurance records)

Thank you for enrolling for Group Insurance with Fort Dearborn Life Insurance Company[®]. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file 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.