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 CERTIFICATE.

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 currently working with the Employer listed on this application? ☐ Yes ☐ No		Employee ID/Payroll #
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.
Any reference to Spouse also applies to Registered Domestic Partner.

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. Does any person applying for coverage have comprehensive health benefits from an insurance policy or HMO plan? If "No," you are not eligible for this coverage.	☐ Yes	☐ No	☐ Yes	☐ No
3. Will coverage applied for replace or modify any individual health insurance coverage?	☐ Yes	☐ No	☐ Yes	☐ No

If "Yes," provide details below and complete and submit required replacement forms if needed.

Insured's Name	Insurance Company Name	Policy Number

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. Have you or your spouse (if applying) been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
Note: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
3. In the past 10 years, have you or your spouse (if applying) been diagnosed by a member of the medical profession, received medical advice, sought treatment including surgery, or taken medication for any of the following:	☐ Yes ☐ No	☐ 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) or emphysema (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 by a member of the medical profession, 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	☐ Yes ☐ No
5. In the past 10 years, have you or your spouse (if applying) been diagnosed by a member of the medical profession, 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	☐ 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 profession for skin cancer including basal cell carcinoma, squamous cell carcinoma or Clark's Level I or II melanoma?	☐ Yes ☐ No	☐ 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

2. Have you ever been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:

   (a) – Cirrhosis of the liver, hepatitis (excluding hepatitis A)
   – Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)
   – Angina, heart attack, coronary artery disease or surgery on the heart or heart valve(s), congestive heart failure or cardiomyopathy
   – Stroke or transient ischemic attack (TIA)
   – Peripheral Vascular Disease
   – Major organ failure (liver, heart, lung, pancreas)
   – Diabetes (excluding gestational)
   – Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)..... ☐ 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).

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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 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.**

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