



You recently elected Supplemental Insurance coverage for you and/or your dependents. In order to determine your eligibility for this insurance, you are required to complete the following Evidence of Insurability form in its entirety, including the applicable medical questions.

Please read the application carefully and complete all of the requested information about you and/or your dependents. Please see the check list below and follow the Instructions and Information for Completing the Evidence of Insurability Form on the following page. If the requested information is not provided the review for coverage could be delayed.

About you:

- Employee Social Security Number
- Employee height and weight (only required if you are electing coverage for yourself)
- Employee Name
- Number and Street Address, City, State ZIP
- Date of Employment
- Occupation
- Employee Annual Salary
- Employee – Total coverage amount if applying for Life Insurance
- Employee – If this is an increase indicate the prior amount of coverage in force
- Employee signature and date (The date should be current and the date that you sign the EOI application.)

About your dependents (*Only required if you are applying for dependent coverage*):

- Dependent(s) name and date of birth
- Dependent(s) height and weight
- Dependent(s) – Total coverage amount if applying for Life Insurance
- Dependent(s) – If this is an increase indicate the prior amount of coverage in force
- Dependent(s) signature and date for any applicant over age 18

Please return the completed form directly to:

Unum
P.O. Box 9783
Portland, ME 04104-5083
Or Fax form to 1-207-771-4019

If you have any questions regarding the Evidence of Insurability application or the status of your medical underwriting decision, please call Unum at **1-800-421-0344**.



INSTRUCTIONS AND INFORMATION FOR COMPLETING THE EVIDENCE OF INSURABILITY FORM

Unum Life Insurance Company of America (Unum)

Completed

- | | |
|--|--------------------------|
| 1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance. Specify what coverage you are requesting. If you are unsure, check with your plan administrator. | <input type="checkbox"/> |
| 2. Make sure you have answered all the questions completely and accurately. If there are unanswered questions, the underwriting process will be delayed. | <input type="checkbox"/> |
| 3. If you have answered Yes to any of the health questions, provide the complete name and mailing address of the doctor or facility that has your medical records. | <input type="checkbox"/> |
| 4. Please include your work and home phone number, we may need to request additional information by telephone. | <input type="checkbox"/> |
| 5. Sign and date where indicated. Keep this page and last copy of the form for your records. Please send the completed form to your plan administrator or Unum representative. | <input type="checkbox"/> |

In order to evaluate your application we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your doctors. Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. These tests will be performed at your convenience and can be completed at your place of employment or home. We will notify you if any additional information is needed. Unum will pay for any additional information or tests needed to evaluate your application.

CAUTION: If your answers on the application are incorrect or untrue, Unum may deny benefits or rescind your insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.



EVIDENCE OF INSURABILITY

Unum Life Insurance Company of America, Portland, Maine
(hereinafter called "Company")

Social Security No.		Applicant/Employee E-mail Address		Group Policy No.(s)		Individual Certificate No.		Approval Requested for:					
Applicant/Employee Name				Employer's Name						<input type="checkbox"/> Applicant / Employee <input type="checkbox"/> Dependent(s)			
Home Address				Employer's Address						Coverages:			
City		State		Zip		City		State		Zip		<input type="checkbox"/> Life \$ _____ <input type="checkbox"/> LTD \$ _____ <input type="checkbox"/> Portability \$ _____ <input type="checkbox"/> STD \$ _____ <input type="checkbox"/> Other _____	
Date of Employment (mm/dd/yyyy)		Applicant Phone Number (H)		Applicant Phone Number (W)		Occupation		Annual Salary					
Name of Persons Applying For Coverage			Sex	Date of Birth (mm/dd/yyyy)		Place Of Birth		Height		Weight		Type of Application <input type="checkbox"/> Initial Request <input type="checkbox"/> Late Applicant <input type="checkbox"/> Increase - Indicate Prior Amount of Coverage in Force \$ _____	
Applicant													
Spouse													
Child													
Child													
Child													

The following questions apply to all persons applying for coverage:

1. During the past 7 years have you been diagnosed or received treatment from a member of the medical profession for any heart disorder, high blood pressure, stroke, cancer, tumor, diabetes, alcoholism, kidney or liver disease, AIDS, respiratory, mental, nervous condition or emotional disorder, arthritis, strained or injured back, slipped disk or any bone, joint or muscle disorder? Applicant need not disclose HIV test results.
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

2. Are you currently using or have you ever used barbiturates, amphetamines, cocaine, hallucinogenic drugs, or any narcotics except as prescribed by a doctor or been advised to reduce your consumption of alcohol or been treated, arrested in connection with alcohol, or been told to have counseling for the use of alcohol or drugs?
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

3. Do you have any condition which prevents or limits work, school attendance or usual activities or are you now pregnant?
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

4. Do you take prescription drugs or medications for any physical, mental, nervous condition or emotional disorder?
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

5. During the past 5 years, other than for conditions listed above, have you consulted or been treated by a member of the medical profession or been hospitalized?
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

6. Do you have any health symptoms or complaints for which you have not consulted a member of the medical profession or received treatment?
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

7. Have you applied for or been issued insurance which has been declined, rated up, modified or renewal refused?
Applicant / Employee: Yes No **Spouse:** Yes No **Child:** Yes No

Please provide details of yes answers below. If additional space is required, please use a separate sheet.

Question No.	Name	Problem/History—If For Blood Pressure Give Recent Reading	Date (mm/dd/yyyy)	Duration	Treatment	Names and Addresses of Physicians, Doctors and Hospitals

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 for which Evidence of Insurability is required. I have read and understand the Authorization and Disclosure Statements and have retained a copy of my completed application for my records.

Applicant / Employee Signature _____ Date (mm/dd/yyyy) _____ Spouse Signature _____ Date (mm/dd/yyyy) _____

Signature of children applying, 18 or older
1186-94

Authorization to Obtain Information

I authorize any person or organization to give Unum or Unum's legal representative any of the following:

- information about any injury or illness I have or I have had, including AIDS, mental illness or drug or alcohol abuse. This authorization excludes disclosure of the result of a test for HIV. Such test results shall not be disclosed or published. I understand that nothing in this caveat will prohibit this authorization from including the fact that an applicant has AIDS.
- information about my medical history including any consultations, prescriptions, treatments or benefits;
- copies of all records that may be requested concerning me or my family members, and
- non-medical information about me or my family members.

The term person or organization, which is used above, means any of the following:

- a doctor or medical practitioner;
- a hospital, clinic or other medical treatment facility;
- the Medical Information Bureau, Inc.;
- any insurance or reinsurance company;
- any insurance support or reporting agency;
- any pharmacy;
- any government agency;
- any employer.

I understand that the information obtained by use of this authorization will be used by Unum to determine eligibility for insurance and eligibility for benefits. Unum will not release any of the obtained information to any other person or organization except:

- reinsuring companies
- the Medical Information Bureau, Inc.
- persons or organizations performing business or legal services in connection with my application or claim as may be otherwise lawfully required or, as I may further authorize.

I understand that this authorization shall be valid for two years from the date shown on the application and that a photographic copy of this authorization shall be as valid as the original.

Disclosure

Notice of Insurance Information Practices

The information collected about you by Unum may in certain circumstances be disclosed to third parties without your specific authorization as permitted by law. You have a right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of Unum's information practices please contact Unum, Attn: Group Medical Underwriting, 2211 Congress Street, Portland, ME 04122.

Medical Information Bureau, Inc. Disclosure

Information regarding insurability will be treated as confidential. Unum may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or if you submit a claim for benefits to such a company, the Bureau will supply the company with the information in its file if that information is requested.

Unum or its reinsurers may also release information in the Bureau file to other life insurance companies to whom you may apply for life or health insurance or to whom you submit a claim for benefits.

If you request it, the Bureau will arrange disclosure of any information it may have in your file. However, medical information will be disclosed only to your doctor. If you request the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. The telephone number is 866-692-6901.

The purpose of the Bureau is to protect its member companies and their policyholders from bearing the additional cost of providing coverage to those people who attempt to conceal facts which relate to their eligibility. Information furnished by the Bureau may alert the Insurer to the possible need for further investigation, but it should be noted that any information received from the Bureau cannot be used as the basis for evaluating a person proposed for coverage. The Bureau is not a repository of medical records, and the information in its files does not reveal whether previous applications for coverage have been accepted, rated for extra risk, or declined.

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Unum
Attn: Medical Underwriting
P.O. Box 9783
Portland, ME 04104-5083

NOTE: Please sign and return this authorization to the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

AUTHORIZATION

I authorize any person or organization to give Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, Unum Insurance Company, or their duly authorized representatives or subsidiaries (individually or collectively referred to as "Unum") any of the following:

- Information about any condition, injury, or illness I have or may have had, including: disorders of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS); mental or physical history, condition, advice, or treatment (but not psychotherapy notes); drug or alcohol use. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results.
- Information about my medical history including any consultations, prescriptions or prescription drug history, treatments or benefits
- Information that may be requested concerning me or my family members, including non medical information such as driving record, consumer reports, earnings or employment history
- Information about other insurance coverage, claims, or benefits

The terms person or organization mean a physician or medical practitioner, a hospital, clinic or other medical facility, health plan, any insurance or reinsurance company, insurance service provider, third party administrator, producer, insurance support organization or consumer reporting agency, data sources, pharmacy or pharmacy benefit manager, government entity, motor vehicle agency, or employer.

I understand the information obtained with this authorization will be used by Unum to determine eligibility for insurance and benefits. Once my information is disclosed to Unum, privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum will not release any of the information to a third party except reinsuring companies or other persons or organizations performing services in connection with my application, coverage, or claim, or as otherwise permitted by law.

I understand that this authorization shall be valid for two years from its date and that a photographic or electronic copy shall be as valid as the original. I understand that I have the right to revoke this authorization at any time except to the extent it has been relied on prior to written notice of revocation. I also understand that, if I revoke or alter this authorization, it may be a basis for denying insurance coverage or benefits. I can revoke this authorization by sending written notice to the address above.

I have read and understand this authorization, and I and my authorized representatives have a right to receive a copy. I understand that failure to sign this authorization may impair Unum's ability to process my application or evaluate a claim, and that this may be a basis for denying my application or claim for benefits.

(Applicant Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the applicant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.