Dearborn National

Underwritten by Dearborn National® Life Insurance Company

The University of Texas System
Evidence of Insurability Application
Voluntary Group Term Life Insurance (VGTL), Short Term Disability and/or Long Term Disability

To be completed by the Employee/Retired Employee:

☐ **New Hire (Date _____)**

☐ **Annual Enrollment Change**

☐ **Qualified Change in Status Event**

(Date of Event _____)

(Reason _____)

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

This form cannot be considered unless received by Dearborn National® Life Insurance Company (Dearborn National) within 30 days following the end of your initial eligibility period, a qualified change in 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, Dearborn National accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days. **Do NOT apply for the UT SELECT Medical plan on this application, as evidence of insurability is not required to enroll in the UT SELECT Medical plan. Please contact your institution Benefits Office if you have any questions about enrollment in the UT SELECT Medical plan.**

You are applying for (Check all that apply and please do NOT reapply for existing coverage):

☐ **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:

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

Social Security No. or Benefits ID	☐ Employee ☐ Retired Employee Name: Last First MI	Sex ☐ Male ☐ 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 (Please do NOT reapply for existing coverage)

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

	Current Coverage Amount	Check the Total Coverage(s) you are applying for:
Employee VGTL Coverage	$ _____	☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x Earnings
Employee's Spouse VGTL Coverage	$ _____	☐ $25,000 ☐ $50,000
Retired Employee VGTL Coverage	$ _____	☐ $7,000 ☐ $10,000 ☐ $25,000 ☐ $50,000
Retired Employee's Spouse VGTL Coverage	$ _____	☐ $3,000

DISABILITY INSURANCE (Employees only) (Please do NOT reapply for existing coverage)

☐ **Short Term Disability** ☐ **Long Term Disability** (Underwritten by Dearborn National® Life Insurance Company)

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

(Please do NOT reapply for existing coverage)

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.
Spouse					

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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 conditions(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)?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
4. Within the past 5 years, has any person applying for coverage been treated for a mental, emotional or nervous disorder, used barbituates, 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?	☐ Yes ☐ No	☐ Yes ☐ No
5. Is there a current use of prescribed medications or use in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
7. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
9. Any surgical operation performed or advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
11. Is any person applying for coverage currently pregnant? If **"Yes"**, indicate anticipated delivery date_____. **Provide details of current/prior complications.**	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No

Explanation of "Yes" answers in Section D - Please provide details of "Yes" answers below. Please complete Form No. UT-EOI-App-412-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

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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 dependent, if applicable, under the Group Policies. Further, I understand that, except where specifically provided in the Group Policies, Dearborn National 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 Dearborn National, and additional medical information, including blood work, may be required to approve such insurance. I also understand that I am responsible to report to Dearborn National 's medical underwriting department any change in my health or that of my dependent, if applicable, prior to the date of approval of this Application, and that coverage will not become effective until Dearborn National 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 Dearborn National to consider this 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, Dearborn National has the right to deny my request for coverage or that of my dependent, 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 Dearborn National 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 Dearborn National.

If my answers on this Application are incorrect or untrue, or if I refuse to sign this authorization, Dearborn National has the right to deny benefits or rescind my coverage or that of my dependent, 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 Dearborn National 's underwriting department, its authorized representative(s) or reinsurers, any information relating to me or my dependent 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**