



**INSTRUCTIONS AND INFORMATION FOR  
COMPLETING THE EVIDENCE OF  
INSURABILITY FORM**  
Unum Life Insurance Company of America

**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.**

1. This form should be fully completed and submitted to Unum when your plan requires you to be individually underwritten to qualify for insurance. If you are not sure what coverages are available under your Unum plan, check with your plan administrator.
2. Make sure you answer all the questions completely and accurately.
3. If applying for coverage for a spouse and/or coverage for a child who is age 18 or older, your spouse or child is required to complete all questions applicable to them. They must also read the Privacy Statement, Authorization and Acknowledgements sections of the form and provide their electronic signature where required. If you are able to access this electronic application only at your workplace, and your spouse or child is not able to comply with these requirements, select "Cancel" and print a hardcopy of the form for completion and mail to Unum.
4. If you choose to "cancel" at any time during the process of completing this electronic application, you will be prompted to print the form. The printed form will contain the information you have entered.

If you choose to print a partially completed form, you may either

- Return to this site, re-enter the information and submit it electronically, or
- Complete the paper copy, sign and date where indicated, and mail the form to:

Unum  
2211 Congress St  
P.O. Box 9783-5083  
Portland, ME 04104

Or Fax the signed form to (207) 771-4022

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 physicians. 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.



EVIDENCE OF INSURABILITY
Unum Life Insurance Company of America

Application Type: [ ] Initial Request [ ] Late Applicant [ ] Annual Enrollment
[ ] Change in Status [ ] Increase [ ] Portability

List Your Current Height

Height input boxes: Ft., In.

Weight

Weight input boxes: Lbs.

List Your Spouse's Current Height

Spouse Height input boxes: Ft., In.

Weight

Spouse Weight input boxes: Lbs.

Employee Social Security Number

Gender

[ ] Male [ ] Female

Group #

Group #

Division #

Employee First Name

Employee First Name input boxes

M.I. Last Name

M.I. Last Name input boxes

Date of Birth - mm/dd/yyyy

Date of Birth slashes

Spouse First Name (if applicable)

Spouse First Name input boxes

M.I. Last Name

Spouse M.I. Last Name input boxes

Spouse Date of Birth - mm/dd/yyyy

Spouse Date of Birth slashes

Number & Street Address

Number & Street Address input boxes

Employee Home Number

Employee Home Number input boxes

City

City input boxes

State

State input boxes

Zip Code

Zip Code input boxes

Employee Work Number

Employee Work Number input boxes

Date of Employment - mm/dd/yyyy Occupation

Date of Employment slashes

Occupation input boxes

Employee Annual Salary

Employee Annual Salary input boxes with dollar sign

E-mail Address

E-mail Address input boxes

Coverages Elected

[ ] Life [ ] LTD [ ] STD

Employer's Name

Employer's Name input boxes

Employer's Address

Employer's Address input boxes

City

City input boxes

State

State input boxes

Zip Code

Zip Code input boxes

Employee

Total Life Amount Applied For

Employee Total Life Amount input boxes

Amount Requiring Underwriting

Employee Amount Requiring Underwriting input boxes

Spouse

Total Life Amount Applied For

Spouse Total Life Amount input boxes

Amount Requiring Underwriting

Spouse Amount Requiring Underwriting input boxes

Names of Dependent Children Applying for Coverage

Date of Birth - mm/dd/yyyy

Total Life Amount

Child Name input boxes

Child Date of Birth slashes

Child Total Life Amount input boxes with dollar sign

Child Name input boxes

Child Date of Birth slashes

Child Total Life Amount input boxes with dollar sign

Child Name input boxes

Child Date of Birth slashes

Child Total Life Amount input boxes with dollar sign

**Please answer the following questions to the best of your knowledge and belief:**

| <p><b>Has any person</b> applying for coverage been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Applicant need not disclose Human Immunodeficiency Virus (HIV) test results.</p>   | <p align="center"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>  |   |   |        |        |   |   |
|--|--|---|---|--------|--------|---|---|
| <p><b>Section 1 Dependent Children Health Questions</b></p>  |  |   |   |        |        |   |   |
| <p>1. <b>Within the past 5 years</b>, have any dependent(s) been treated for diabetes, heart disorder, or cancer (other than basal or squamous cell carcinoma of the skin)? Do any dependent(s) have cerebral palsy, cystic fibrosis or muscular dystrophy? If yes, please provide name(s) of children.</p>  | <p align="center"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>  |   |   |        |        |   |   |
| <p><b>Section 2 Employee and Spouse Health Questions</b></p>   |  |   |   |        |        |   |   |
| <p><b>All employees and spouses applying for coverage must complete this section.</b></p>  |  |   |   |        |        |   |   |
| <p>1. <b>Within the past 2 years</b>, have you used any controlled substances with the exception of those prescribed by a physician, received medical advice or sought treatment for drug or alcohol abuse, or pled guilty, pled no contest to or been convicted of a felony, misdemeanor, or a charge of operating a motor vehicle under the influence of drugs and/or alcohol?</p>   | <table border="1"> <tr> <th align="center">Employee</th> <th align="center">Spouse</th> </tr> <tr> <td align="center">Yes No</td> <td align="center">Yes No</td> </tr> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table> | Employee  | Spouse  | Yes No | Yes No | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| Employee   | Spouse   |   |   |        |        |   |   |
| Yes No   | Yes No   |   |   |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>2. <b>Within the past 2 years</b>, have you been prescribed three or more medications to be taken concurrently for high blood pressure?</p>   | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>3. <b>Within the past 5 years</b>, have you received medical advice or sought treatment for psychosis, internal cancer including melanoma, leukemia or Hodgkin's disease, ALS, muscular dystrophy, angina, or had heart surgery, heart attack or transient ischemic attack (TIA)?</p>   | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>4. <b>Within the past 10 years</b>, have you received medical advice or sought treatment for stroke, congestive heart failure, chronic lung disease including emphysema, diabetes treated with insulin or oral medications, hepatitis (other than type A), cirrhosis of the liver, chronic renal disease including hypertension or failure, systemic lupus or any connective tissue disease?</p>  | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>5. <b>Are you confined</b> to a wheelchair for reasons other than paraplegia?</p>   | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p><b>Section 3 If your amount requiring underwriting is greater than \$150,000 or you are applying for disability coverage, you must complete section 3. Otherwise, please sign and return application.</b></p>   |  |   |   |        |        |   |   |
| <p><b>If you answer yes, please provide details requested in the box on the following page.</b></p>  |  |   |   |        |        |   |   |
| <p>1. <b>Within the past 2 years</b>, have you flown as a student or private pilot, engaged in auto or boat racing, scuba diving, hang gliding, ballooning, flying ultralights, parachuting, mountain climbing or any similar sport or avocation?</p>  | <table border="1"> <tr> <th align="center">Employee</th> <th align="center">Spouse</th> </tr> <tr> <td align="center">Yes No</td> <td align="center">Yes No</td> </tr> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table> | Employee  | Spouse  | Yes No | Yes No | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| Employee   | Spouse   |   |   |        |        |   |   |
| Yes No   | Yes No   |   |   |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>2. <b>Have you ever</b> used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician 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? If yes, provide the frequency of use and date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number, date of occurrence and driver's license number and issuing state of any arrest.</p> | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>3. <b>Have you ever</b> pled guilty to, pled no contest to or been convicted of a felony or misdemeanor? If yes, list person's name, reason for arrest(s) and/or are you currently on probation.</p>  | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>4. <b>Within the past 2 years</b>, have you pled guilty to, pled no contest to, or been convicted of 3 or more speeding or other moving violations? If yes, list person's name, type of violation(s) and date(s), driver's license number and state of issue.</p>   | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>5. <b>Within the past 10 years</b>, have you received medical advice or sought treatment for epilepsy, nervous, emotional or mental disorder, paralysis, skin, bone, muscle, back, knee, neck or joint disorder, muscular or neurological disorders, Fibromyalgia, or Chronic Fatigue Syndrome. If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>   | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>6. <b>Within the past 7 years</b>, have you received medical advice or sought treatment for diabetes, asthma, lung or respiratory disorder, thyroid or other endocrine disease, heart or circulatory disorder, stroke (including TIA), chest pain, high blood pressure, cancer, gastro-intestinal, genitourinary, kidney or liver disease? If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>  | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>7. <b>Within the past 7 years</b>, have you consistently taken any over the counter medications, natural supplements other than vitamins, or received any therapeutic treatments? If yes, list all over the counter medications including any natural supplements, dosage, condition and date of onset. Please also list therapies and associated conditions and dates treatment received.</p>  | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>8. <b>Within the past 7 years</b>, have any medications been prescribed or have you consulted a medical professional for anything other than the conditions above, or are you currently experiencing any symptoms for which you haven't consulted a medical professional? If yes, provide details including symptoms, dates of occurrence, medications, treatment and medical professional's name, address and phone number.</p>  | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |
| <p>9. <b>Do you have</b> any condition that prevents or limits activities or are you now pregnant? If yes, provide details including symptoms and describe the limitation(s). If pregnant, please provide expected delivery date.</p>  | <table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |        |        |   |   |
| <input type="checkbox"/> <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/>  |   |   |        |        |   |   |

## Details for any "yes" answers

| Question Number | Name | Detailed Description | Date | Duration | Treatment Received and Recovery | Names and Addresses of Physicians and Hospitals |
|-----------------|------|----------------------|------|----------|---------------------------------|---|
|                 |      |                      |      |          |                                 |   |
|                 |      |                      |      |          |                                 |   |
|                 |      |                      |      |          |                                 |   |
|                 |      |                      |      |          |                                 |   |

Please attach additional sheet if you need additional space

## Authorization

I authorize any person or organization to give Unum subsidiaries or their duly authorized representatives (Unum) any of the following:

- information about any injury or illness I have or I have had, including Acquired Immune Deficiency Syndrome (AIDS), mental illness or drug or alcohol abuse. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results. 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 Acquired Immune Deficiency Syndrome (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 a physician or medical practitioner, a hospital, clinic or other medical treatment facility, any insurance or reinsurance company, insurance support or reporting agency, pharmacy, government agency, or 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 or other persons or organizations performing services in connection with my application or claim.

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. 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 this authorization, such revocation may be a basis for denying insurance benefits. This authorization may be revoked by sending written notice to: Unum, Attn: Group Medical Underwriting, P.O. Box 9783, Portland ME 04104-5083.

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 I and my authorized representative 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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child Signature (if 18 or older)

\_\_\_\_\_  
Date



## **Unum's Commitment to Privacy**

Unum understands 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 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, please visit [www.Unum.com/privacy](http://www.Unum.com/privacy) or [www.coloniallife.com](http://www.coloniallife.com) or write to: Privacy Officer, Unum, 2211 Congress Street, C467, 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, 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 The Paul Revere Variable Annuity Insurance Company.*

