

## Term Life Insurance and Accidental Death and Dismemberment

**Term Life Insurance:** In addition to the employer provided basic life, eligible employees may qualify for up to \$500,000 in increments of \$25,000. Legal spouse may qualify for up to \$200,000. Eligible dependent children may qualify for up to \$10,000. Plan includes Waiver of Premium, Accelerated Life, Life Planning.

**Enrollment Forms:** Must be submitted within 31 days of hire or eligibility date. Late enrollments or requests for additional amounts are required to submit evidence of insurability forms.

**Age Reduction:** The amount of basic life, optional life, basic AD&D and optional AD&D coverage is reduced for employee and spouse by 35% at age 65 and by an additional 15% at age 70.

**Accidental Death and Dismemberment:** Employees may qualify for up to \$350,000 in increments of \$25,000. Spouse may qualify for up to \$200,000 in increments of \$25,000. Dependent Children may qualify for up to \$70,000 in increments of \$5,000.

**Open Enrollment:** The employee may annually increase their additional life coverage by \$25,000, within your groups 60-day Open Enrollment period. A completed enrollment form must be submitted and no additional underwriting will be required.

Term Life		
Basic Benefit Employer Paid:		Monthly Rate
Employee:	\$50,000	\$6.60
Eligible Spouse:	\$5,000	\$1.40
Eligible Children:	\$2,500	
Additional Life Employee Paid:		Monthly Rate
Employee:	\$500,000	Age Banded
Eligible Spouse:	\$200,000	Age Banded
Eligible Children:	\$10,000	Call for Details

Accidental Death & Dismemberment		
Basic Benefit Employer Paid:		Monthly Rate:
Employee Only:	\$50,000	\$.65
Additional AD&D Employee Paid:		Monthly Rate:
Employee:	\$350,000	\$.24 per \$1,000 of coverage
Eligible Spouse:	\$200,000	
Eligible Children:	\$70,000	

Additional Life Enrollment Information and Benefits
<b>Seat Belt Benefit:</b> 10% of AD&D Benefit up to \$25,000
<b>Seat belt and Airbag Benefit:</b> 5% of AD&D Benefit up to \$5,000
<b>Eligible Employee:</b> Must be an active full time employee, or belong to a class of employees covered by this plan. <b>Eligible Dependents:</b> Your legal spouse and unmarried dependent children through the end of the month in which your dependent children reach age 27.
<b>Coverage Eligibility Date:</b> For new hires, coverage begins on the 1 <sup>st</sup> of the month following the date of hire or day of eligibility. (ie if hired Jan 15 <sup>th</sup> , coverage begins Feb 1 <sup>st</sup> )
<b>Additional Coverage:</b> Requests for additional coverage, or a change to dependents, requires a new enrollment form along with an Evidence of Insurability Form when required. Forms must be signed and dated within 31 days of a life changing event (ie: birth, death, marriage etc.)
<b>Disabled Dependent Children:</b> Coverage continues beyond age 27 with proper underwriting approval submitted to Unum.



**UTAH LOCAL GOVERNMENTS TRUST**  
 GROUP LIFE and ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)  
 INSURANCE ELECTION FORM  
**POLICY # 606430**

**IMPORTANT!** This form must be returned to your employer prior to the end of the enrollment period.  
**New hire enrollment period:** If your form is not signed, dated and returned *within 31 days after the effective date of this form*, you will automatically be enrolled in the employer-funded plan.  
**Re-enrollment period:** If your form is not signed, dated and returned *before* the effective date of the plan year for which elections are being made, you will remain in the option(s) you had previously, or a plan most similar, although your cost may change.

Name:		Social Security #:	
Address:		City:	Zip:
Phone:	Email:	Annual Salary:	
Date of Hire:	Effective Date:	Date of Birth:	
Member Employer:		ID Code:	

<b>Basic Life and AD&amp;D (Employer-paid)</b>		
Employee: \$50,000	Spouse: \$5,000	Child: (Birth through age 26): \$2,500

DEPENDENT INFORMATION - List the dependents covered by your elections.

\* *Relation to You:* **SP** = spouse; **CH** = child; **ST** = stepchild who lives with you and depends upon your financial support

Name	SSN	Date of Birth	Relation to You*	Male/Female

**PRIMARY BENEFICIARY INFORMATION - Designate your beneficiary (ies) below.**

Name	Relation to You	Benefit
		%
		%
		%

*If the beneficiary (ies) named above are not living, then pay:*  
**SECONDARY BENEFICIARY INFORMATION - Designate your beneficiary (ies) below.**

Name	Relation to You	Benefit
		%

**Additional Life and AD&D (Employee-paid)**

Have any tobacco products been used in the last 12 months? **You:**  Yes  No **Your Spouse:**  Yes  No

**EMPLOYEE:** You may also purchase Additional Employee Life/AD&D coverage in \$25,000 increments to a maximum of \$500,000 for Life and \$350,000 for AD&D.

**Note: Evidence of Insurability (EOI) will be required for Employee Additional Life if:**

- you initially elect coverage that exceeds the \$250,000 Guarantee Issue maximum
- you increase your coverage by more than one level at annual enrollment or you increase your coverage by any level outside annual enrollment
- you had previously opted out of Additional Life and are electing coverage as a Late Entrant (EOI is not required for AD&D)

**SPOUSE:** You may also purchase Additional Spouse Life and AD&D coverage in \$25,000 increments to a maximum of \$200,000 for Life and \$200,000 for AD&D.

**Note: Evidence of Insurability (EOI) will be required for Spouse Additional Life if:**

- you initially elect Spouse coverage that exceeds the \$25,000 Guarantee Issue maximum, **and** you answer YES to the following question: **In the last 6 months**, has your spouse received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer; any condition related to Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex; or any other life threatening condition?

If the answer is NO, you can get \$50,000 in Spouse Additional Life coverage.  YES  NO

- you initially elect Spouse coverage that exceeds \$50,000
- you increase your coverage by any level at anytime
- you had previously opted out of Additional Spouse Life and are electing Spouse coverage as a Late Entrant (EOI is not required for AD&D)

**CHILD(REN):** You may also purchase Child Additional Life and AD&D Coverage in \$5,000 increments to a maximum of \$10,000 for Life and \$70,000 for AD&D.

**Note: Evidence of Insurability is not required for Child Life coverage**

Coverage Elections	
<b>EMPLOYEE</b>	<input type="checkbox"/> Life \$ _____ <input type="checkbox"/> AD&D \$ _____ <input type="checkbox"/> I decline Life coverage <input type="checkbox"/> I decline AD&D coverage
<b>SPOUSE</b>	<input type="checkbox"/> Life \$ _____ <input type="checkbox"/> AD&D \$ _____ <input type="checkbox"/> I decline Life coverage <input type="checkbox"/> I decline AD&D coverage
<b>CHILD</b>	<input type="checkbox"/> Life \$ _____ <input type="checkbox"/> AD&D \$ _____ <input type="checkbox"/> I decline Life coverage <input type="checkbox"/> I decline AD&D coverage

See page 3 & 4 for Additional Life and AD&D rates.

**Additional Life (Employee Paid) Rates NON TOBACCO**

Coverage	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00	\$125,000.00	\$150,000.00	\$175,000.00	\$200,000.00	\$225,000.00	\$250,000.00
Under 30	\$1.10	\$2.20	\$3.30	\$4.40	\$5.50	\$6.60	\$7.70	\$8.80	\$9.90	\$11.00
30 - 34	\$1.23	\$2.45	\$3.68	\$4.90	\$6.13	\$7.35	\$8.58	\$9.80	\$11.03	\$12.25
35 - 39	\$1.58	\$3.15	\$4.73	\$6.30	\$7.88	\$9.45	\$11.03	\$12.60	\$14.18	\$15.75
40 - 44	\$2.48	\$4.95	\$7.43	\$9.90	\$12.38	\$14.85	\$17.33	\$19.80	\$22.28	\$24.75
45 - 49	\$4.10	\$8.20	\$12.30	\$16.40	\$20.50	\$24.60	\$28.70	\$32.80	\$36.90	\$41.00
50 - 54	\$6.33	\$12.65	\$18.98	\$25.30	\$31.63	\$37.95	\$44.28	\$50.60	\$56.93	\$63.25
55 - 59	\$9.05	\$18.10	\$27.15	\$36.20	\$45.25	\$54.30	\$63.35	\$72.40	\$81.45	\$90.50
60 - 64	\$15.38	\$30.75	\$46.13	\$61.50	\$76.88	\$92.25	\$107.63	\$123.00	\$138.38	\$153.75

Coverage	\$275,000.00	\$300,000.00	\$325,000.00	\$350,000.00	\$375,000.00	\$400,000.00	\$425,000.00	\$450,000.00	\$475,000.00	\$500,000.00
Under 30	\$12.10	\$13.20	\$14.30	\$15.40	\$16.50	\$17.60	\$18.70	\$19.80	\$20.90	\$22.00
30 - 34	\$13.48	\$14.70	\$15.93	\$17.15	\$18.38	\$19.60	\$20.83	\$22.05	\$23.28	\$24.50
35 - 39	\$17.33	\$18.90	\$20.48	\$22.05	\$23.63	\$25.20	\$26.78	\$28.35	\$29.93	\$31.50
40 - 44	\$27.23	\$29.70	\$32.18	\$34.65	\$37.13	\$39.60	\$42.08	\$44.55	\$47.03	\$49.50
45 - 49	\$45.10	\$49.20	\$53.30	\$57.40	\$61.50	\$65.60	\$69.70	\$73.80	\$77.90	\$82.00
50 - 54	\$69.58	\$75.90	\$82.23	\$88.55	\$94.88	\$101.20	\$107.53	\$113.85	\$120.18	\$126.50
55 - 59	\$99.55	\$108.60	\$117.65	\$126.70	\$135.75	\$144.80	\$153.85	\$162.90	\$171.95	\$181.00
60 - 64	\$169.13	\$184.50	\$199.88	\$215.25	\$230.63	\$246.00	\$261.38	\$276.75	\$292.13	\$307.50

**Additional Life (Employee Paid) Rates TOBACCO**

Coverage	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00	\$125,000.00	\$150,000.00	\$175,000.00	\$200,000.00	\$225,000.00	\$250,000.00
Under 30	\$2.15	\$4.30	\$6.45	\$8.60	\$10.75	\$12.90	\$15.05	\$17.20	\$19.35	\$21.50
30 - 34	\$2.78	\$5.55	\$8.33	\$11.10	\$13.88	\$16.65	\$19.43	\$22.20	\$24.98	\$27.75
35 - 39	\$3.58	\$7.15	\$10.73	\$14.30	\$17.88	\$21.45	\$25.03	\$28.60	\$32.18	\$35.75
40 - 44	\$5.70	\$11.40	\$17.10	\$22.80	\$28.50	\$34.20	\$39.90	\$45.60	\$51.30	\$57.00
45 - 49	\$9.23	\$18.45	\$27.68	\$36.90	\$46.13	\$55.35	\$64.58	\$73.80	\$83.03	\$92.25
50 - 54	\$13.80	\$27.60	\$41.40	\$55.20	\$69.00	\$82.80	\$96.60	\$110.40	\$124.20	\$138.00
55 - 59	\$18.55	\$37.10	\$55.65	\$74.20	\$92.75	\$111.30	\$129.85	\$148.40	\$166.95	\$185.50
60 - 64	\$29.40	\$58.80	\$88.20	\$117.60	\$147.00	\$176.40	\$205.80	\$235.20	\$264.60	\$294.00

Coverage	\$275,000.00	\$300,000.00	\$325,000.00	\$350,000.00	\$375,000.00	\$400,000.00	\$425,000.00	\$450,000.00	\$475,000.00	\$500,000.00
Under 30	\$23.65	\$25.80	\$27.95	\$30.10	\$32.25	\$34.40	\$36.55	\$38.70	\$40.85	\$43.00
30 - 34	\$30.53	\$33.30	\$36.08	\$38.85	\$41.63	\$44.40	\$47.18	\$49.95	\$52.73	\$55.50
35 - 39	\$39.33	\$42.90	\$46.48	\$50.05	\$53.63	\$57.20	\$60.78	\$64.35	\$67.93	\$71.50
40 - 44	\$62.70	\$68.40	\$74.10	\$79.80	\$85.50	\$91.20	\$96.90	\$102.60	\$108.30	\$114.00
45 - 49	\$101.48	\$110.70	\$119.93	\$129.15	\$138.38	\$147.60	\$156.83	\$166.05	\$175.28	\$184.50
50 - 54	\$151.80	\$165.60	\$179.40	\$193.20	\$207.00	\$220.80	\$234.60	\$248.40	\$262.20	\$276.00
55 - 59	\$204.05	\$222.60	\$241.15	\$259.70	\$278.25	\$296.80	\$315.35	\$333.90	\$352.45	\$371.00
60 - 64	\$323.40	\$352.80	\$382.20	\$411.60	\$441.00	\$470.40	\$499.80	\$529.20	\$558.60	\$588.00

**Accidental Death and Dismemberment Rates**

Coverage	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00	\$125,000.00	\$150,000.00	\$175,000.00	\$200,000.00	\$225,000.00	\$250,000.00
Employee	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00	\$3.60	\$4.20	\$4.80	\$5.40	\$6.00
Spouse	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00	\$3.60	\$4.20	\$4.80		
child	\$0.60	\$1.20	call for rate							
Coverage	\$275,000.00	\$300,000.00	\$325,000.00	\$350,000.00						
Employee	\$6.60	\$7.20	\$7.80	\$8.40						

**Note:** Life coverage amounts may not be payable if you commit suicide within 24 months of your effective date of coverage. See your Plan Administrator or refer to your employee booklet for details about AD&D coverage exclusions.

**Delayed Effective Date:** (1) Employee – Initial insurance, and any increased or additional insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective. (2) Dependents - Initial insurance coverage will be delayed if a dependent is totally disabled on the date that insurance would otherwise be effective. Exception: Newborn children are insured from birth.

**Request for Signature:** I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline Employee or Spouse coverage at initial eligibility and later decide to elect the coverage, I will be required to submit Evidence of Insurability for any amount elected and will have to be approved by Unum’s Medical Underwriting Dept.

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

\_\_\_\_\_  
Date



**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.**

To expedite processing, this form has been designed to be scanned and optically read. Please print neatly and respond to all questions.

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.
2. Make sure you have answered all the questions completely and accurately. Information pertaining to your Employer name, address and Group number, as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.
3. All employees and spouses applying for any coverage requiring underwriting must answer all health questions through section 1. If your life amount requiring underwriting is greater than \$150,000, you must also fill out section 2.
4. Please include your work and home phone number; we may need to request additional information by telephone.
5. Please sign and date where indicated and make a copy of this form for your records. Please send the completed form to your plan administrator or mail the form directly to:

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

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.

Reorder as CU-5838 (09/15)



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

Employee Social Security Number input boxes

Gender

[ ] Male [ ] Female

Group #

Group # input boxes

Group #

Group # input boxes

Division #

Division # input boxes

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 input boxes

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 input boxes

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

Date of Employment input boxes

Occupation

Occupation input boxes

Employee Annual Salary

Employee Annual Salary input boxes with dollar sign

E-mail Address

E-mail Address input boxes

Coverage Elected

[ ] Life

Member Employer's Name

Member 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

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

<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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section 1 Employee and Spouse Health Questions</b>		<b>Employee</b>	<b>Spouse</b>
<b>All employees and spouses applying for coverage must complete this section.</b>		<b>Yes No</b>	<b>Yes No</b>
<b>1. 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?		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>2. Within the past 2 years,</b> have you been prescribed three or more medications to be taken concurrently for high blood pressure?		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>3. 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)?		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>4. 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?		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>5. Are you confined</b> to a wheelchair for reasons other than paraplegia?		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>Section 2 If your amount requiring underwriting is greater than \$150,000, you must complete section 2. Otherwise, please sign and return application.</b>		<b>Employee</b>	<b>Spouse</b>
<b>If you answer yes, please provide details requested in the box on the following page.</b>		<b>Yes No</b>	<b>Yes No</b>
<b>1. 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?		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>2. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>3. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>4. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>5. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>6. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>7. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>8. 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.		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>9. 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.		<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



## **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, 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, 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.*

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