Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

APPLICATION FOR
GROUP LIFE INSURANCE
Evidence of Insurability

Application Type: ☐ Initial Request ☐ Annual Enrollment ☐ Late Applicant ☐ Change in Status ☐ Rehire ☐ Increase ☐ Reinstatement

SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always Complete.

Employee Name (First, Middle, Last) _____

Social Security Number _____

Home Address (Street/PO Box) _____

Gender ☐ F ☐ M

City _____

Date of Birth (mm/dd/yyyy) _____

State _____ Zip Code _____

Home Phone # _____

Are you Actively at Work? ☐ Yes ☐ No

Employee ID/Payroll # _____

Do you Work for the Employer in the U.S.? ☐ Yes ☐ No

Date of Hire (mm/dd/yyyy) _____

Employer Name _____

Group Number # _____

Occupation _____

Street/PO Box _____

Annual Salary $ _____

City _____

Work Phone # _____

State _____ Zip Code _____

Scheduled Number of Work Hours per Week _____

SECTION 2: SPOUSE INFORMATION – Complete Only if Applying for Spouse Coverage

Name (First, Middle, Last) _____

Social Security Number _____

Date of Birth (mm/dd/yyyy) _____

Gender ☐ F ☐ M

SECTION 3: DEPENDENT INFORMATION – Complete Only if applying for Dependent Coverage (Attach a separate sheet for additional dependents)

Names of Dependent Children Applying for Coverage — **Date of Birth (mm/dd/yyyy)**

Child 1 _____ Gender ☐ F ☐ M _____

Child 2 _____ Gender ☐ F ☐ M _____

Child 3 _____ Gender ☐ F ☐ M _____

Employee Name: _____ (Applicant)

Employee SSN: _____ (Applicant)

SECTION 4: COVERAGE INFORMATION – To be completed for Employee (Applicant) and Spouse and/or Child if applicable. Indicate the coverage amounts you would like to select for you (and your spouse and/or Child, if applicable). Any items left blank will result in a coverage amount equal to $0.

	Employee (Applicant)
The following question should be answered by the Employee (Applicant): Have you used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?	☐ Yes ☐ No

Amount of Coverage Selected For:

Employee: $ _____

Spouse: $ _____

Child: $ _____

Cost per Paycheck: $ _____

Employee Name: (Applicant) _____ Employee SSN: (Applicant) _____

SECTION 5: TIER 1 MEDICAL PROFILE – Complete as required for all underwritten coverage	Employee (Applicant)	Spouse	Child 1	Child 2	Child 3
1. Provide Height and Weight	_____ ft. _____ in. _____ lbs.	_____ ft. _____ in. _____ lbs.	N/A	N/A	N/A
2. Have you (or any person applying for coverage) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months, have you (or any person applying for coverage) for any reason other than vacation, colds, flu, pregnancy, accidents, allergies or back problems been hospitalized more than 5 consecutive days, or if employed, missed more than 10 consecutive days at work?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 5 years, have you (or any person applying for coverage) been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following: - Atrial fibrillation, angina, heart attack, coronary artery disease or surgery on the heart or heart valve(s) - Congestive heart failure or cardiomyopathy - Stroke or transient ischemic attack (TIA) - High blood pressure treated with 3 or more medications - Alcohol or drug abuse - Diabetes (excluding gestational or diet controlled) - Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 10 years, have you (or any person applying for coverage) been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind, excluding basal cell carcinoma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Has the Child applicant ever been diagnosed with or treated for: Down's syndrome, cerebral palsy, muscular dystrophy or cystic fibrosis?	N/A	N/A	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee Name: (Applicant) _____ Employee SSN: (Applicant) _____

SECTION 6: TIER 2 MEDICAL PROFILE – Complete if additional underwriting is required	Employee (Applicant)	Spouse	Child 1	Child 2	Child 3
1. Have you (or any person applying for coverage) ever been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following: - Cirrhosis of the liver or hepatitis (excluding hepatitis A) - Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma) - Atrial fibrillation, angina, heart attack, coronary artery disease or surgery on the heart or heart valve(s) - Congestive heart failure or cardiomyopathy - Stroke or transient ischemic attack (TIA) - Peripheral Vascular Disease - Cancer (excluding basal cell carcinoma) - Any condition requiring an organ transplant (excluding corneal) - Diabetes (excluding gestational or diet controlled) - Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 5 years, have you (or any person applying for coverage) been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following: - Multiple sclerosis, muscular dystrophy or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) or Huntington's disease - Schizophrenia, psychosis, bipolar disorder or post traumatic stress disorder - Crohn's disease or ulcerative colitis - Systemic lupus or any connective tissue disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 2 years, have you (or any person applying for coverage): - Pled guilty or no contest or been convicted of a felony or misdemeanor - Been charged with operating a motor vehicle under the influence of drugs and/or alcohol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee Name: _____ (Applicant)

Employee SSN: _____ (Applicant)

SECTION 7: EMPLOYEE (APPLICANT) STATEMENTS

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter "Unum") and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to you. If you pay part or all of the cost of your coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin. If your employer pays the full cost of your coverage, the effective date will be no earlier than the first day of the month following the date you become eligible for coverage.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premium).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

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

Employee (Applicant) Signature

Date (mm/dd/yyyy): _____

Spouse Signature (if required)

Date (mm/dd/yyyy): _____

Child Signature (if 18 or older and if required)

Date (mm/dd/yyyy): _____