

How to complete the Online Evidence of Insurability (EOI) Form

1. Click on the link in the email to be directed to the following screening:

The screenshot shows the Unum logo at the top left. Below it, a header reads "You are completing the evidence of insurability portion of your application" with a "Help" icon on the right. The main content area is titled "Getting Started" and contains instructions for completing the form, including a list of required information: Dates, Duration, Treatment received and date of recovery, and Names and addresses of physicians and hospitals. A "Questions" sidebar on the right provides additional help and a PDF download option. At the bottom of the form, there is a "START" button.

2. Select **Yes** or **No** to the US resident question and click **Start**.

This screenshot shows a specific question: "Are you a U.S. resident?[*]". Below the question are two radio button options: "Yes" (which is selected) and "No". To the right of the options is a large "START" button.

3. Read through the Introduction page. Click **Next** when you are ready to proceed.

The screenshot shows the "Introduction" page with a list of instructions for completing the application. The instructions include: 1. Fully complete and submit the application. 2. Review responses to ensure all required information is completed. 3. If not submitting electronically, print and complete the application by hand, then fax or mail it to Unum. Contact information for Unum is provided: 2015 Congress Street, P.O. Box 9783-5083, Portland, ME 04104-9038. A "CAUTION" note at the bottom states that Unum may deny benefits or rescind coverage if the application contains false, incomplete, or misleading information. At the bottom of the page are "BACK" and "NEXT" buttons.

4. The Employer section is automatically populated with Multnomah County's information. Click **Next** to continue.

This screenshot shows the "Employer or Sponsor Information" section of the form. The "Employer or Sponsor Name[*]" field is populated with "Multnomah County Oregon". The "Address" field contains "501 SE Hawthorne Blvd". Below this, there are three fields: "City" (Portland), "State" (Oregon), and "Zip" (97214). At the bottom of the section are "BACK" and "NEXT" buttons.

5. Under **Application Type**, select **Electing coverage during yearly enrollment**.

Note: All The Fields with an asterisk [*] are mandatory

Application Type (Reason for filling out this form)[*]
 -- Select One --
 First time eligible for coverage
 Change in your family status; ie: Marriage, Birth, etc.
 Late; did not apply when first eligible
 Electing a higher level of coverage
 Electing coverage during yearly enrollment

Spouse: Life
 Child: Life

Social Security Number [*] | Gender[*] | Group[*] | Group
 | - Select - | 285369 | 387791 | 001

6. Elect the plan(s) you would like to enroll in during open enrollment (Employee Life/Spouse Life).
 NOTE: Do not select LTD or STD or Child Life.

Electing coverage during yearly enrollment

Elected Coverages Requiring Evidence of Insurability

Employee: Life LTD STD
 Spouse: Life

7. Enter your information. The correct Group and Division # have already been filled in. Once you have completed all of the required fields click **Next** to continue.

Employee Information

Note: All The Fields with an asterisk [*] are mandatory

Application Type (Reason for filling out this form)[*]
 Electing coverage during yearly enrollment

Elected Coverages Requiring Evidence of Insurability

Employee: Life LTD STD
 Spouse: Life
 Child: Life

Social Security Number [*] | Gender[*] | Group[*] | Group | Division[*]
 | - Select - | 285369 | 387791 | 001

First Name [*] | M.I. | Last Name [*] | Date of Birth [*] (mm/dd/yyyy)
 | | | | |

Number and Street Address[*] | Home Phone Number
 | | | |

Address line 2
 | | | |

City[*] | State[*] | Zip[*] | Work Phone Number
 | | | | |

Date of Employment[*] (mm/dd/yyyy) | Occupation
 | | | |

Annual Salary[*]
 | | | | (Please enter whole dollars, without \$ sign or cents.)

E-mail Address
 | | | | |

8. Enter your information - height, weight and the dollar amount of life insurance you want to enroll in.
 *Enter Life Insurance amount with no dollar signs, commas or decimal point (ex. 150000)

Click **Calculate** to populate the box under **Amount Requiring Underwriting**.

a. Employee: minimum \$30,000; maximum \$500,000. Guarantee Issue amount \$150,000

Employee coverage information

List your current height: Ft. [*] 5 | In. [*] 3 | Weight[*] 200 lbs.

Total Life Amount Applied For [*]
 220000

Total amount of life insurance requested. Enter whole dollars, without dollar sign or cents.
 Current Life Amount [*]
 100000

the amount of life insurance you currently have with Unum. Enter whole dollars, without dollar sign or

Examples:

- Applying for the first time within your enrollment period? Enter your plan guaranteed issue amount.
- Applying for the first time after your enrollment period (applying late)? Enter zero (0).
- Increasing your Life amount? Enter the amount of Life coverage you already have.

- Applying for the first time within your enrollment
- Applying for the first time after your enrollment
- Increasing your Life amount? Enter the amount

Amount Requiring Underwriting [*]
 120000

amount of life insurance requiring evidence of insurability and what you are requesting. Enter whole dollars, with

9. Complete the same steps for your spouse,
 Spouse: minimum \$30,000, maximum \$500,000. Guarantee Issue amount \$50,000

Spouse Information

First Name[*] M.I. Last Name[*] Date of Birth[*] (mm/dd/yyyy)
 Michael F Dummy 05/01/1948

Spouse Coverage

Spouse's Current Height: Ft.[*] 5 in.[*] 4 Weight[*] 300 lbs.
 Total Life Amount Applied For[*]
 500000
 total amount of life insurance requested. Enter whole dollars, without dollar sign or cents.
 Current Life Amount[*]
 250000
 the amount of life insurance you currently have with Unum. Enter whole dollars, without dollar sign or cents.

Examples:

- Applying for the first time within your enrollment period? Enter your plan guaranteed issue amount.
- Applying for the first time after your enrollment period (Applying late)? Enter zero (0).
- Increasing your Life amount? Enter the amount of Life coverage you already have.

Calculate

Amount Requiring Underwriting [*]
 250000
 amount of life insurance requiring evidence of insurability; i.e. difference between what you currently have and what you are requesting. Enter whole dollars, without dollar sign or cents.

KBACK **NEXT**

10. Answer the health questions for you and your spouse and click **Next** to continue.

Health Questions

Answer all questions to the best of your knowledge and belief. [*]

• Has any person applying for coverage been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Applicant need not disclose Human Immunodeficiency Virus (HIV) test results. Yes No

Dependent Children Health Questions[*] Yes No

• Within the past 5 years, 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.

Employee and Spouse Health Questions[*] Employee Spouse Yes No Yes No

• Within the past 2 years, 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?

• Within the past 2 years, have you been prescribed three or more medications to be taken concurrently for high blood pressure?

• Within the past 5 years, have you received medical advice or sought treatment for psychosis, internal cancer including melanoma, leukemia or Hodgkin's disease, ALC, muscular dystrophy, angina, or had heart surgery, heart attack or transient ischemic attack (TIA)?

• Within the past 10 years, 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 connecting tissue disease?

• Are you confined to a wheelchair for reasons other than paraplegia?

If your amount requiring underwriting is greater than \$150,000 or you are applying for disability coverage, you must complete this section. [*]
 If you answer yes, please provide details requested on the following page.

11. Please read the **Privacy Statement** completely and click **Next** to continue.

You are submitting evidence of insurability information to obtain Unum benefit coverage

Privacy Statement

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

12. Read the **Authorization** section completely. Select **Agree** or **Disagree** and click **Next** to proceed.

Authorization

I authorize any person or organization to give Unum Group 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 9783-5083, Portland ME 04104.

I Agree I Disagree

BACK **NEXT**

13. Read the **Acknowledgement** section. Select **Agree** or **Disagree**, then type your name (and your spouse's name if you select life insurance for your spouse) and enter the date. Click **Review** to review the entire application. Click **Submit** to submit your application to Unum.

You are submitting evidence of insurability information to obtain Unum benefit coverage

Acknowledgement

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.

I agree and intend that by typing my name and clicking on "I Agree" I am providing my signature for all purposes. By providing my signature in this manner, I hereby confirm my intention to be bound by and authenticate this application and the information it contains.

I Agree I Disagree

Employee Signature[*]	Date[*] (mm/dd/yyyy)
Test M Dummy	06/16/2016
Spouse Signature[*]	Date[*] (mm/dd/yyyy)
Michael Dummy	06/16/2016

Please Note: If additional medical information is required, we will request a physical signature for your spouse.

REVIEW

Prior to electronically submitting this application, I have reviewed my answers for accuracy and printed a copy of this application for my records.

BACK **SUBMIT**