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:

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

Are you a U.S. resident?[*]

Yes No

START

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

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

Employer or Sponsor Information

Employer or Sponsor Name[*]
Multnomah County Oregon
Address
501 SE Hawthorne Blvd
City
Portland
State
Oregon
Zip
97214

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

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.

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.

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

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

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

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

'ou 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 includ telephone number, address, date of birth, occupation, income and health history. We may receive NPI fron 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 medic 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 case

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 fo 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

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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.

'ou 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[*] Test M Dummy — Date[*] (mm/dd/yyyy) 06/16/2016

Spouse Signature[*] Michael Dummy — Date[*] (mm/dd/yyyy) 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.

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