Instructions and Information for completing the Statement of Health form

To expedite processing print neatly and respond to all questions on the form

Application Type

- ☐ Newly Eligible *(This is the first time I have been eligible for coverage)*
- ☐ Change to Existing Coverage (*I am electing a higher level of coverage)*
- ☐ Late; did not apply when first eligible
- ☐ Electing coverage during yearly enrollment

Section 1

Mobile Telephone Number: Provide the best number to reach you in case clarification is needed to process your application.
Policy Number: If not known, please consult with your HR Representative.
Division Number: If not known, please consult with your HR Representative.

Section 2

Complete if applying for spouse coverage.

Section 3

Only complete if applying for child coverage. If you have dependent children with any of the conditions listed, please check "Yes" and write the name(s) in the space provided.

Section 4

Neatly write in the coverage you are requesting. Please write clearly and indicate if the coverage is for the employee (EE), spouse (SP) or child (CH) if applicable.

Coverage Selections:

Coverage options:

Group Life – indicate amount (see instructions below)
Critical Illness - indicate amount
Group Long Term Disability (LTD) – write "LTD" in the box if applying for long term disability
Group Short Term Disability (STD) – write "STD" in the box if applying for short term disability

Employee (EE)	Spouse (SP)	Child (CH)
Life Amount of requested EE Life coverage Amount of existing EE Life coverage	**Life** Amount of requested SP Life coverage Amount of existing SP Life coverage	**Life** Amount of requested CH Life coverage Amount of existing child Life coverage -Names and DOB for all children –
Critical Illness Write in EE coverage amount	**Critical Illness** Write YES or NO for SP coverage	**Critical Illness** Automatically included with EE coverage at no additional charge

Section 5

Complete for all applicants requesting coverage.

Section 6

Complete in full if applying for disability coverage. Provide details for any "yes" answers in **Section 7.**

Section 8

Sign and date where indicated. It's important to retain a copy for your records. Call 1-800-421-0344 with questions or send the completed form through one of these methods:

If you are enrolling in coverage or changing existing coverage, please use the following:

Fax: 1-207-771-4019

Mail: UNUM
P.O. Box 9783
Portland, ME 04104-5083

Email: **UNUMEOI@UNUM.COM**

If continuing insurance from your former employer, please use the following:

Fax: 1-207-575-2993

Mail: UNUM
Portability conversion – C372
2211 Congress Street
Portland, ME 04122

Email: **PortabilityConversion@UNUM.com**

Some coverage and amounts may require supplemental information (e.g., blood test, urinalysis, EKG). These tests will be performed at your convenience and UNUM will cover the cost. If additional information is needed, we will notify you via the contact information provided in Section 1.

STATEMENT OF HEALTH

(Evidence of Insurability)

☐ **Unum Life Insurance Company of America,** 2211 Congress Street, Portland, ME 04122
☐ **Provident Life and Accident Insurance Company,** 1 Fountain Square, Chattanooga, TN 37402
☐ **Unum Insurance Company,** 2211 Congress Street, Portland, ME 04122

Application Type: ☐ Newly Eligible ☐ Late; did not apply when first eligible ☐ Change to Existing Coverage ☐ Electing coverage during yearly enrollment

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Sex ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Mobile Telephone Number
Email Address		Work Phone Number
Employer Name		Date of Hire (mm/dd/yyyy)
Address (Street/PO Box)		Occupation
City		Annual Salary
State		Zip Code
Policy Number		Division Number

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage

Spouse Name (First, Middle, Last)

Social Security Number	Sex ☐ F ☐ M	Date of Birth (mm/dd/yyyy)

SECTION 3: Status Questions

Employee:

1. Are you working and able to perform the duties required for your job? ☐ Yes ☐ No
2. Are you a U.S. citizen, a Canadian citizen working in the U.S., or a permanent resident of the U.S. with a valid green card, or a holder of a H1B or H2 visa? ☐ Yes ☐ No

Spouse (if applying):

1. Is your spouse living in the U.S., or, if not, is your spouse a U.S. citizen? ☐ Yes ☐ No
2. In the past 12 months, has your spouse been admitted to a hospital or confined in a nursing facility, or missed five or more consecutive days of work for health reasons, other than for cold, flu, pregnancy, accidents, allergies, or back problems. ☐ Yes ☐ No

Within the last 5 years, has any dependent child (or grandchild, if applicable) for whom you are seeking coverage been diagnosed with, or treated by, a medical professional for diabetes, heart disorder, cancer (other than basal cell or squamous cell of the skin), Acquired Immune Deficiency Syndrome (AIDS), Down syndrome, cerebral palsy, muscular dystrophy or cystic fibrosis? Applicant should answer "no" as to AIDS if the child has tested positive for Human Immunodeficiency Virus (HIV) but has no diagnosis or symptoms of the disease AIDS. ☐ Yes ☐ No

If "yes," provide names of dependents with condition:

Employee (Applicant) Name: _____ SSN: _____

SECTION 4: Coverage Selections

SECTION 5: Health Questions

Employee Height/Weight: ____ft.____in._____lbs. Spouse Height/Weight: ____ft.____in._____lbs.

Within the last 5 years, have you (or your spouse, if applying) had a diagnosis by a medical professional, or received treatment by a medical professional for any of the following:	**Employee Yes | No**	**Spouse Yes | No**
1. Acquired Immune Deficiency Syndrome (AIDS)? Applicant should answer "no" if tested positive for Human Immunodeficiency Virus (HIV) but does not have a diagnosis or symptoms for AIDS.	☐ ☐	☐ ☐
2. Cancer or malignancy other than basal cell or squamous cell of the skin	☐ ☐	☐ ☐
3. Heart disease, coronary artery disease, heart failure, any heart surgery or disease of an artery	☐ ☐	☐ ☐
4. Lung disease (other than asthma) or lung failure	☐ ☐	☐ ☐
5. Hepatitis (other than hepatitis A), liver failure, cirrhosis of the liver, chronic pancreatitis, Barrett's esophagus, Crohn's disease or ulcerative colitis	☐ ☐	☐ ☐
6. Chronic kidney disease (other than kidney stones) or renal failure	☐ ☐	☐ ☐
7. Stroke, muscular dystrophy, myasthenia gravis, multiple sclerosis, transient ischemic attack (TIA), amyotrophic lateral sclerosis (ALS), or Huntington's disease	☐ ☐	☐ ☐
8. Rheumatologic disease (other than osteoarthritis) or systemic lupus erythematosus (SLE)	☐ ☐	☐ ☐
9. Parkinson's disease	☐ ☐	☐ ☐
10. Diabetes (other than gestational or diet-controlled), Cushing's disease or Addison's disease, pancreatic failure	☐ ☐	☐ ☐
11. Disease of abnormal bleeding or clotting or blood disease (other than iron deficiency anemia in pre-menopausal women or HIV)	☐ ☐	☐ ☐
12. Schizophrenia, psychiatric hospitalization or attempted suicide	☐ ☐	☐ ☐
13. Dementia or Alzheimer's disease	☐ ☐	☐ ☐
14. Drug or alcohol abuse, dependence or addiction	☐ ☐	☐ ☐
15. Glaucoma or retinal degeneration	☐ ☐	☐ ☐
Within the last 2 years have you (or your spouse, if applying) pled guilty or no contest to, or been convicted of, a felony or operating a motor vehicle under the influence of drugs and/or alcohol?	☐ ☐	☐ ☐

Employee (Applicant) Name: _____ SSN: _____

SECTION 6:	**Disability Health Questions** Complete if applying for new or increased long or short term disability. Otherwise, continue to Section 8. (Disability coverage is only available for employees)	
Within the last 5 years, have you had a diagnosis by a medical professional or received treatment by a medical professional for any of the following. Include in the table below the dosage of all prescription and over the counter medications.		**Employee Yes | No**
1. Disease of the veins, high blood pressure, or abnormal cholesterol, headache or disease of the brain or nervous system		☐ ☐
2. Disease of the esophagus, stomach, intestines, rectum, liver, pancreas, gall bladder, bladder or reproductive organs		☐ ☐
3. Disease of the bone, joints, muscles, neck, or back; or have you had a joint replacement or an amputation		☐ ☐
4. Any disease of the eyes, ears, nose, throat, skin, endocrine disease (including thyroid disease), or asthma		☐ ☐
5. Chronic fatigue syndrome, fibromyalgia, chronic Lyme disease, postural orthostatic tachycardia syndrome (POTS), multiple chemical sensitivity		☐ ☐
6. Any psychiatric or psychological disease or disorder, including depression or anxiety		☐ ☐
7. Have you had a pregnancy with complications or are you currently pregnant?		☐ ☐
8. Have you had a disease or injury for which you have been prescribed any medication or consulted a medical professional, other than for the conditions above (other than HIV)?		☐ ☐
Are you currently experiencing any symptoms of a physical or mental illness or condition, for which you haven't consulted a medical professional, or do you have any physical or mental illnesses or conditions that prevent or limit your activities?		☐ ☐

SECTION 7: For every "yes" answer in Section 6, please provide the following information:

Condition	Treatment such as medications (including dosage), surgery, or other therapy	Date of Treatment (mm/yyyy)	Name and address of treating physician and/or medical facility
		Started:	
		Ended: (or note on-going)	
		Started:	
		Ended: (or note on-going)	
		Started:	
		Ended: (or note on-going)	

Please attach additional sheets if you need more space.

Employee (Applicant) Name: _____ SSN: _____

SECTION 8: Certification – Please read, sign, date and submit as part of your application.

State Required Notices I confirm that I have read the state required notices attached and I attest that each statement as it applies to me or those for whom I am electing coverage is accurate.

Certification I understand that coverage is not effective until approved. All statements and information found in this application are deemed representations and not warranties. All statements and answers provided above, on behalf of myself or another person, are true and complete and are given, to obtain insurance and may be relied upon by Unum. If the information is incorrect, or untrue, Unum may deny benefits or rescind (void) the coverage to the extent allowed under the plan's incontestability provisions.

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 on state law.
PLEASE SEE DIFFERENT FRAUD WARNING ATTACHED THAT MAY APPLY IN YOUR STATE

Employee (Applicant) Signature	**Date (mm/dd/yyyy)**
Spouse Signature	**Date (mm/dd/yyyy)**
Child (if >17) Signature	**Date (mm/dd/yyyy)**

Please return completed form using one of the following options:
email to UnumEOI@unum.com, fax to 207-771-4019,
or mail to: Unum, P.O. Box 9783, Portland, ME 04104-5083

Unum
Attn: Medical Underwriting
P.O. Box 9783
Portland, ME 04104-5083

NOTE: Please sign and return this authorization to the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

AUTHORIZATION

I authorize any person or organization to give Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, Unum Insurance Company, or their duly authorized representatives or subsidiaries (individually or collectively referred to as "Unum") any of the following:

- Information about any condition, injury, or illness I have or may have had, including: disorders of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS); mental or physical history, condition, advice, or treatment (but not psychotherapy notes); drug or alcohol use. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results.
- Information about my medical history including any consultations, prescriptions or prescription drug history, treatments or benefits
- Information that may be requested concerning me or my family members, including non medical information such as driving record, consumer reports, earnings or employment history
- Information about other insurance coverage, claims, or benefits

The terms person or organization mean a physician or medical practitioner, a hospital, clinic or other medical facility, health plan, any insurance or reinsurance company, insurance service provider, third party administrator, producer, insurance support organization or consumer reporting agency, data sources, pharmacy or pharmacy benefit manager, government entity, motor vehicle agency, or employer.

I understand the information obtained with this authorization will be used by Unum to determine eligibility for insurance and benefits. Once my information is disclosed to Unum, privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum will not release any of the information to a third party except reinsuring companies or other persons or organizations performing services in connection with my application, coverage, or claim, or as otherwise permitted by law.

I understand that this authorization shall be valid for two years from its date and that a photographic or electronic copy 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 or alter this authorization, it may be a basis for denying insurance coverage or benefits. I can revoke this authorization by sending written notice to the address above.

I have read and understand this authorization, and I and my authorized representatives 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.

_____ _____
(Applicant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the applicant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. 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 perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations

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, with parties for 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.

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.

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, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. 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 the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and 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 and 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 to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we 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. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

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, Unum Insurance Company, 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 Starmount Life Insurance Company.