Group Life Insurance Evidence of Insurability

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098 • Fax 651-665-7092

MINNESOTA LIFE

EMPLOYER NAME: City of St. Louis **POLICY NUMBER: 34098**

EMPLOYEE INFORMATION (always complete for coverage that requires evidence of insurability)

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Street address	City	State	Zip code

Date of birth	Social Security number	Date of employment	Gender ☐ Male ☐ Female

Total amount of Optional Life insurance requested	Email address

SPOUSE/DOMESTIC PARTNER INFORMATION (only complete if coverage requires evidence of insurability)

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Date of birth	Email address	Gender ☐ Male ☐ Female

Total amount of Spouse/Domestic Partner Basic + Optional Dependent Life insurance requested	Email address

CHILDREN INFORMATION (only complete if coverage requires evidence of insurability; list names and dates of birth)

Total amount of Child Basic + Optional Dependent Life insurance requested

HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee Yes	Employee No	Spouse/DP Yes	Spouse/DP No	Children Yes	Children No		Employee Height	Employee Weight	Spouse/domestic partner Height	Spouse/domestic partner Weight	Occupation
☐	☐	☐	☐	☐	☐	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s) or been hospitalized?					
☐	☐	☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?					
☐	☐	☐	☐	☐	☐	3. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?					

If you answer "Yes" to any question, please provide additional information below or on a separate sheet of paper.

ADDITIONAL HEALTH INFORMATION (provide details for every "Yes" answer to the health questions)

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

FOR OFFICE USE ONLY:

Employee Optional Life			Spouse/Domestic Partner Basic + Optional Dependent Life			Children Basic + Optional Dependent Life		
Current in force	U/W applied for	Total elected	Current in force	U/W applied for	Total elected	Current in force	U/W applied for	Total elected
x/$	x/$	x/$	$	$	$	$	$	$

PLEASE READ & SIGN NEXT PAGE & SEND ALL PAGES TO MINNESOTA LIFE

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand I am entitled to receive a copy of this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send the Company a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or your rights, you may contact:

Group Division Underwriting
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
MIB Telephone: (866) 692-6901
MIB TTY: (866) 346-3642
Website: www.mib.com

I have read this Authorization and Consumer Privacy Notice and I understand I can have copies. The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I authorize my employer to withdraw premiums from my salary to pay for this coverage. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee name (please print)		Date of birth	
Employee signature X	Daytime phone number	Evening phone number	Date signed
Spouse/domestic partner/dependent name (please print)		Date of birth	
Spouse/domestic partner/dependent signature X	Daytime phone number	Evening phone number	Date signed