



(Please retain with your insurance records)

Thank you for enrolling for Group Insurance with Fort Dearborn Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PLEASE RETURN THIS APPLICATION TO FORT DEARBORN LIFE INSURANCE COMPANY AFTER COMPLETION.

You must complete both pages in full and the application must be signed and dated on Page 2 to be considered for coverage.

This form cannot be considered unless received by FDL within 30 days of completion. Insurance for an applicant will not be effective unless and until FDL accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

Please print preferably in black ink.

Section A: EMPLOYEE/RETIREE DATA (This section must be filled out completely for application to be considered.)

Please provide the A&M System from which you are employed or retired (i.e., Prairie View A&M Univ.)

| | | | | | | | | |
|-------------------------------|--|----------------------|------|--|----------------------|----------------|----------------|--------|
| Social Security No. | <input type="checkbox"/> Employee/ <input type="checkbox"/> Retiree Name: Last | First | M.I. | Sex | Date of Birth | State of Birth | Height | Weight |
| - | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Mo./ Day/ Yr. / / | | Ft. / In. / | Lbs. |
| Home Mailing Address – Street | | | | City | State | Zip | | |
| Date Employed/Retired | Annual Salary | Daytime Phone () | | Evening Phone () | Email Address | | | |

Section B: GROUP TERM LIFE COVERAGES. I am applying below if I check the box in front of that coverage description.

Basic Life coverage of \$5,000, or
 Alternate Basic Life (available if you do not have A&M System health coverage but certify that you have other health coverage) – Choose \$50,000 or less, in thousands
Current Coverage Amount In Force \$ _____ **Additional Amount Applied For \$** _____ **Total Coverage (Combined) \$** _____

Optional Life. **Check one:** ½ x 1x 2x 3x 4x 5x 6x annual salary
Current Coverage Amount In Force \$ _____ **Additional Amount Applied For \$** _____ **Total Coverage (Combined) \$** _____
**The maximum coverage amount for retirees is \$60,000*

I am a: **Check one:** 12-month employee 9-month employee 10.5-month employee Other _____ Retiree

Dependent Life. **Check one:** Plan A (spouse coverage = 50%; child coverage = 10% of your Optional Life coverage)
 Plan B (Life and AD&D coverage of \$5,000 on your enrolled spouse and each enrolled child)
 Plan C (spouse coverage = 50%; child coverage = 10% of your Alternate Basic Life coverage)
Current Coverage Amount In Force \$ _____ **Additional Amount Applied For \$** _____ **Total Coverage (Combined) \$** _____
***Total of all dependents combined if applying for your spouse and child(ren)*

Section C: DEPENDENT COVERAGE List all dependents applying for coverage (complete only if requesting insurance)

| | | | | | | | | |
|---|----------------------|-------|---------------|--|----------------------|----------------|----------------|--------|
| Social Security No. | Spouse Name: Last | First | M.I. | Sex | Date of Birth | State of Birth | Height | Weight |
| - | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Mo./ Day/ Yr. / / | | Ft. / In. / | Lbs. |
| Daytime Phone () | Evening Phone () | | Email Address | | | | | |
| Relationship to Employee/Retiree | Name: Last | First | M.I. | Social Security No. | Date of Birth | Height | Weight | |
| | | | | | Mo. / Day / Yr. | Ft. In | Lbs. | |
| 1. <input type="checkbox"/> Daughter <input type="checkbox"/> Son | | | | - | - / / | | | |
| 2. <input type="checkbox"/> Daughter <input type="checkbox"/> Son | | | | - | - / / | | | |
| 3. <input type="checkbox"/> Daughter <input type="checkbox"/> Son | | | | - | - / / | | | |
| 4. <input type="checkbox"/> Other Specify _____ | | | | - | - / / | | | |

Section D: HEALTH INFORMATION (This section must be filled out completely for application to be considered).

The following questions must be answered fully and truthfully for any person applying for coverage.
 During the last 5 years, has any person applying for coverage been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in questions 1 - 12 below? Check either "Yes" or "No" to each question, circle the specific condition, and give details at the end of this section.

| | Yes | No |
|---|--------------------------|--------------------------|
| 1. Has any person applying for coverage used cigarettes or other tobacco products in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign or malignant)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Alcohol and/or drug addiction and/or substance abuse/treatment, mental, emotional or any other nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there a current use of prescribed medications or use in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions 1 through 6? | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | |
|---|--|------------------------------------|--------------------------|
| Section D: HEALTH INFORMATION (Cont.) | | Yes | No |
| 9. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints? -1- | | <input type="checkbox"/> | <input type="checkbox"/> |
| Employee/Retiree Name _____ | | Social Security No. - - | |
| 11. Any surgical operation performed or been advised to have any performed? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has any person applying for coverage been in a hospital or sanitarium for rest, treatment, observation or diagnosis: undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions 1 through 11? | | <input type="checkbox"/> | <input type="checkbox"/> |

Explanation of "Yes" answers in Section D

If the answer is "Yes" to any of the conditions in Section D, please indicate the question number and give details below. If additional space is required, please complete and attach a separate signed and dated sheet.

| # | Person | Condition | Dates From / To | Hospitalized Yes / No | Surgery Yes / No | Treatment / Medication | Current Medication / Any Remaining Problems | Physician's Full Name |
|---|--------|-----------|-----------------|-----------------------|------------------|------------------------|---|-----------------------|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

AGREEMENTS AND AUTHORIZATION – Please read carefully before signing.

I, the undersigned applicant(s), have read and agree that, to the best of my knowledge and belief, all written, telephonic and electronic information I have provided in support of my Application is complete, true and correctly recorded. I understand that insurance subject to medical questions requires FDL approval, and additional medical information, including blood work, may be required to approve such insurance. I also understand that I am responsible to report to FDL's medical underwriting department any change in my health prior to the date of approval of this Application, and that coverage will not become effective until FDL approves my application, provided that I am actively at work on that date. Further, I understand that, except where specifically provided in the Group Policies, Fort Dearborn Life Insurance Company (FDL) and The Texas A& M University System shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to the date of approval of my request for insurance.

I understand and agree that:

- This authorization is voluntary and that my signature is required in order for FDL to consider this application and to make a determination on whether to accept and issue the coverage(s) applied for herein;
- If I refuse to sign this authorization, FDL has the right to deny my request for coverage or that of my spouse, if applicable;
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- I have received a Disclosure Statement;
- This authorization shall expire 24 months from the date it is signed;
- All correspondence regarding coverage for those individuals listed on this Application will be sent to the Employee/Retiree.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from FDL.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, employer, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department, its authorized representative(s) or reinsurers, any information relating to me concerning medical history, advice, care, treatment or diagnosis for any health condition, including but not limited to drug or alcohol abuse, mental illness or physical condition, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to the MIB Group, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Signature of Employee/Retiree

Date

Signature of Spouse (if requesting insurance)

Date

Signature of Dependent Child – age 18 and older (if requesting insurance)

Date