



**INSTRUCTIONS AND INFORMATION FOR  
COMPLETING THE EVIDENCE OF  
INSURABILITY FORM**  
Unum Life Insurance Company of America  
2211 Congress Street, Portland, Maine 04122

**UnumProvident is the marketing brand. The insurance product is underwritten by Unum Life Insurance Company of America.**

To expedite processing, this form has been designed to be scanned and optically read. Please print neatly and respond to all questions.

1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance. Specify what coverage you are requesting. If you are unsure, check with your plan administrator.
2. Make sure you have answered all the questions completely and accurately. Information pertaining to your Employer name, address and Group number, as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.
3. All employees and spouses applying for any coverage requiring underwriting must answer all health questions through section 2. If you are applying for disability coverage, or your life amount requiring underwriting is greater than \$150,000, you must also fill out section 3.
4. Please include your work and home phone number; we may need to request additional information by telephone.
5. Sign and date where indicated. Please send the completed form to your plan administrator.

In order to evaluate your application we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your physicians. Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. These tests will be performed at your convenience and can be completed at your place of employment or home. We will notify you if any additional information is needed. UnumProvident will pay for any additional information or tests needed to evaluate your application.

**CAUTION:** If your answers on the application are incorrect or untrue, UnumProvident may deny benefits or rescind your insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.



<p><b>Has any person</b> applying for coverage been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Applicant need not disclose Human Immunodeficiency Virus (HIV) test results.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No								
<p><b>Section 1 Dependent Children Health Questions</b></p>									
<p>1. <b>Within the past 5 years</b>, 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.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No								
<p><b>Section 2 Employee and Spouse Health Questions</b></p>									
<p><b>All employees and spouses applying for coverage must complete this section.</b></p>	<p><b>Employee</b>    <b>Spouse</b></p>								
<p>1. <b>Within the past 2 years</b>, 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?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>2. <b>Within the past 2 years</b>, have you been prescribed three or more medications to be taken concurrently for high blood pressure?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>3. <b>Within the past 5 years</b>, have you received medical advice or sought treatment for psychosis, internal cancer including melanoma, leukemia or Hodgkin's disease, ALS, muscular dystrophy, angina, or had heart surgery, heart attack or transient ischemic attack (TIA)?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
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<p>4. <b>Within the past 10 years</b>, 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 connective tissue disease?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>5. <b>Are you confined</b> to a wheelchair for reasons other than paraplegia?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p><b>Section 3 If your amount requiring underwriting is greater than \$150,000 or you are applying for disability coverage, you must complete section 3. Otherwise, please sign and return application.</b></p>	<p><b>Employee</b>    <b>Spouse</b></p>								
<p><b>If you answer yes, please provide details requested in the box on the following page.</b></p>	<p><b>Yes No</b>    <b>Yes No</b></p>								
<p>1. <b>Within the past 2 years</b>, have you flown as a student or private pilot, engaged in auto or boat racing, scuba diving, hang gliding, ballooning, flying ultralights, parachuting, mountain climbing or any similar sport or avocation?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>2. <b>Have you ever</b> used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician or been advised to reduce your consumption of alcohol or been treated, arrested in connection with alcohol, or been told to have counseling for the use of alcohol or drugs? If yes, provide the frequency of use and date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number, date of occurrence and driver's license number and issuing state of any arrest.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>3. <b>Have you ever</b> pled guilty to, pled no contest to or been convicted of a felony or misdemeanor? If yes, list person's name, reason for arrest(s) and/or are you currently on probation.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>4. <b>Within the past 2 years</b>, have you pled guilty to, pled no contest to, or been convicted of 3 or more speeding or other moving violations? If yes, list person's name, type of violation(s) and date(s), driver's license number and state of issue.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>5. <b>Within the past 10 years</b>, have you received medical advice or sought treatment for epilepsy, nervous, emotional or mental disorder, paralysis, skin, bone, muscle, back, knee, neck or joint disorder, muscular or neurological disorders, Fibromyalgia, or Chronic Fatigue Syndrome. If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
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<p>6. <b>Within the past 7 years</b>, have you received medical advice or sought treatment for diabetes, asthma, lung or respiratory disorder, thyroid or other endocrine disease, heart or circulatory disorder, stroke (including TIA), chest pain, high blood pressure, cancer, gastro-intestinal, genitourinary, kidney or liver disease? If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>7. <b>Within the past 7 years</b>, have you consistently taken any over the counter medications, natural supplements other than vitamins, or received any therapeutic treatments? If yes, list all over the counter medications including any natural supplements, dosage, condition and date of onset. Please also list therapies and associated conditions and dates treatment received.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
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<p>8. <b>Within the past 7 years</b>, have any medications been prescribed or have you consulted a medical professional for anything other than the conditions above, or are you currently experiencing any symptoms for which you haven't consulted a medical professional? If yes, provide details including symptoms, dates of occurrence, medications, treatment and medical professional's name, address and phone number.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<p>9. <b>Do you have</b> any condition that prevents or limits activities or are you now pregnant? If yes, provide details including symptoms and describe the limitation(s). If pregnant, please provide expected delivery date.</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

**Details for any "yes" answers.**

Question Number	Name	Detailed Description	Date	Duration	Treatment Received and Recovery	Names and Addresses of Physicians and Hospitals

Please attach additional sheet if you need additional space

**Authorization**

I authorize any person or organization to give UnumProvident Corporation subsidiaries or their duly authorized representatives (UnumProvident) any of the following:

- information about any injury or illness I have or I have had, including AIDS, mental illness or drug or alcohol abuse. This authorization excludes disclosure of 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 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 UnumProvident to determine eligibility for insurance and eligibility for benefits. UnumProvident 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: UnumProvident, Attn: Group Medical Underwriting, P.O. Box 9783-5083, Portland ME 04104.

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 UnumProvident'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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child Signature (if 18 or older)

\_\_\_\_\_  
Date



## **UnumProvident's Commitment to Privacy**

UnumProvident understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information. This notice explains why we collect information about you, what we do with the information and how we protect your privacy.

### *Collecting Information*

The UnumProvident insuring companies offer products and services designed to help people balance their work and personal lives, return to independence after a disabling illness or injury, and protect their incomes and assets from the financial effects of disability and death. To provide these benefits and to service policies, we must collect nonpublic personal information about our customers. This may include telephone number, address, date of birth, occupation, income information, physical condition and health history.

In addition to the information in applications and other forms, we may receive information from medical service providers, other insurance companies, consumer reporting agencies, employers, insurance support organizations and service providers.

### *Sharing Information*

We treat nonpublic personal information as confidential. We share the types of information described above primarily with people who perform insurance, business and professional services for us or when otherwise required or permitted by law. When necessary, we ask your permission before sharing information about you. Our information-sharing practices apply to our former, current and future customers.

We understand you may be particularly concerned about the confidentiality of your health information. Please be assured we do not share your nonpublic personal health information to market any product or service. We also do not share any information about you to market non-financial products and services. For example, we do not sell your name to catalog companies.

We may, however, share non-health information to market financial products and services. For example, we may share with companies that help us market our insurance products and services or with other financial institutions to jointly market financial products and services. When required, we ask your permission before sharing information for marketing purposes.

When other companies help us conduct business, we expect them to maintain the confidentiality of information about you and abide by all applicable privacy laws. We do not authorize them to use or share the information except when necessary to conduct the work they are performing for us or to meet insurance regulatory or other governmental requirements.

UnumProvident companies, including insurers and insurance service providers, may share information about you with each other. This information 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 this information.

## *Safeguarding Information*

UnumProvident has physical, electronic and procedural safeguards in place to protect the confidentiality and security of information about you. It is our policy to give access only to those employees who need to know the information to provide insurance products or services to you.

## *Accuracy of Information*

We want to make sure the information we collect about you to provide you with your policy is accurate. You may request access to that information, as well as information related to recent disclosures. You may ask us to correct or delete inaccuracies. If we agree, we will make the appropriate changes. If we disagree, you may submit a statement of dispute, which we will include any time the information is shared.

## *Contacting Us*

To receive UnumProvident's complete privacy notice, including more about our information-sharing, access and correction practices, write to: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. For additional information about UnumProvident's commitment to privacy, visit [www.unumprovident.com/privacy](http://www.unumprovident.com/privacy).

*UnumProvident Corporation is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.*

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