Fields highlighted in red may be filled out on your computer

**MINNESOTA LIFE**

# GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY

Minnesota Life Insurance Company ● B2-4930 ● 400 Robert Street North ● St. Paul, Minnesota 55101-2098

## EMPLOYER INFORMATION

EMPLOYER NAME: **University of Notre Dame**

POLICY NUMBER: **32620-G**

## APPLICANT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)

SOCIAL SECURITY NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

DATE OF BIRTH (MO./DAY/YR.)

☐ MALE ☐ FEMALE

HEIGHT

WEIGHT

OCCUPATION

ANNUAL SALARY $

OPTIONAL INSURANCE CURRENTLY ENROLLED IN $

REQUESTED INCREASE IN OPTIONAL INSURANCE REQUIRING EVIDENCE OF INSURABILITY $

## HEALTH QUESTIONS

**APPLICANT**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 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 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 your answer to questions 1, 2 or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment below. Use the reverse side if additional space is needed.

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, (the Company), St. Paul, Minnesota 55101-2098 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 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 If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I 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 understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. This authorization is valid for 26 months. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice on the reverse side of this form, and I understand that I can have copies.

I understand that premiums for all supplemental coverages will be deducted from the employee's pay.

APPLICANT SIGNATURE

X

DAYTIME TELEPHONE NUMBER

( )

DATE SIGNED

Ed. F. 58319 9-2002

MHC-96-13220

## CONSUMER PRIVACY NOTICE

In addition to the information requested on this application, the Company may ask for the following: an insurance medical exam or laboratory tests; medical records from your physician, hospital, or your insurance company; an investigative consumer report; a report from the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The Company or its reinsurer may make a brief report of this information to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

The Company may also send information about you to the following persons or organizations without your permission: to insurance organizations, for statistical studies, without identifying you; to a government agency involved in regulation of insurance; to your physician (the results of your insurance exam).

You have certain rights in connection with this insurance application. You have the right to: find out what personal information is contained in the Company or MIB files; correct or amend information in the Company or MIB files; know the specific reasons why coverage is not issued.

At your request, the Company will explain in writing how you can exercise your right to learn what is in your file, how to correct or amend it, or how to find out why coverage is not issued.

**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

**For information about the Medical Information Bureau, you may contact:**

Medical Information Bureau Information Office
P.O. Box 105, Essex Station
Boston, Massachusetts 02112
(MIB telephone number: (617) 426-3660)

## ADDITIONAL HEALTH INFORMATION:

| DATE | NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL | REASON FOR CONSULTATION | DIAGNOSIS AND TREATMENT |
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| FOR HOME OFFICE USE ONLY: | | |
|---|---|---|
| **Applicant** | | |
| CURRENT IN FORCE<br>$ | U/W APPLIED FOR<br>$ | |
| ☐ APPR'D ☐ DECL. ☐ INCOM. | BY | DATE |