BlueCross BlueShield of Texas

FORT DEARBORN LIFE Insurance Company

# EVIDENCE OF INSURABILITY APPLICATION

## UT Select Medical Plan and/or Voluntary Group Term Life Insurance (VGTL)

REMEMBER: You must complete each page in full, and the application must be signed and dated on Page 3 to be considered. Please complete this application in black or blue ink. Return this application to:

Fort Dearborn Life Insurance Company
Administrative Offices, Attn: Medical Underwriting Dept.
P.O. Box 655403
Dallas, Texas 75265-5403

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

You are applying for: ☐ Health ☐ Life ☐ Health and Life

To be completed by the Employee/Retiree.

☐ Annual Enrollment Change

☐ Change in Status Event (Date of Event ____________)

☐ New Hire

☐ Retiree Increase

## Section A: EMPLOYEE/RETIREE DATA

UT System component from which you are employed or retired.

Agency Code: Agency Name:

| Social Security No. or OEB-ID | ☐ Employee ☐ Retiree<br>Name: Last First MI | Sex<br>☐ Male<br>☐ Female | Date of Birth<br>MM DD YYYY<br>/ / | Height<br>Ft. In.<br>/ | Weight<br>Lbs. |
|---|---|---|---|---|---|

| Home Mailing Address – Street | City | State | Zip |
|---|---|---|---|

| Employee Basic Annual Earnings: | Email Address: |
|---|---|

## Section B: REQUESTED COVERAGE

### UT SELECT MEDICAL PLAN

(Administered by Blue Cross and Blue Shield of Texas*)

Check the coverage(s) you are applying for:

- Employee / Retiree Coverage ☐
- Spouse Coverage ☐
- Dependent Coverage ☐

### VOLUNTARY GROUP TERM LIFE INSURANCE (VGTL)

(Underwritten by Fort Dearborn Life Insurance Company)

Check the coverage(s) you are applying for:

- Requested Employee VGTL Coverage Amt. ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x Earnings
- Requested Retiree VGTL Coverage Amt. ☐ $7,000 ☐ $10,000 ☐ $25,000 ☐ $50,000
- Requested Spouse VGTL Coverage Amt. ☐ $15,000 ☐ $40,000

## Section C: SPOUSE DATA to be completed for a spouse applying for the UT Select Medical Plan *or* VGTL Insurance OTHER DEPENDENT DATA to be completed *only if applying for the UT Select Medical Plan*

| Relationship to Employee/Retiree | Name: Last First MI | Social Security No. or OEB-ID | Date of Birth MM / DD / YYYY | Height Ft. / In. | Weight Lbs. |
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***NOTE*: Please complete Form No. UT-EOI-App-06--Dep 2 for additional dependents and please remember to sign and date it.**

**Employee/Retiree Name** ______________________________ **SSN or OEB-ID** ______________________________

## Section D: HEALTH INFORMATION (Answer all questions fully and truthfully for any person applying for coverage.)

| 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 the questions below? Check either "**Yes**" or "**No**" to each question and **circle the specific condition(s). Details to all "Yes" answers must be provided. Omission of any information may result in an adverse underwriting decision.** | **Employee/Retiree** | | **Spouse** | | **Dependent(s)** | |
|---|---|---|---|---|---|---|
| | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| 1. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign or malignant)? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 2. 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? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 3. 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? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 4. Alcohol and/or drug addiction and/or substance abuse/treatment, mental, emotional or any other nervous disorder? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 5. Is there a current use of prescribed medications or use in the last 6 months? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 6. 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? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 7. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions 1 through 6? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 8. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 9. 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? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 10. Any surgical operation performed or advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 11. Is any person applying for coverage currently pregnant? If "**Yes**", indicate anticipated delivery date ______________________________. **Provide details of current/prior complications.** | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| 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? | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ☐ Yes | ☐ No |

## Explanation of "Yes" answers in Section D – Please provide details of "Yes" answers below. Please complete Form No. UT-EOI-App-06-Exp 2 for additional explanation/details of "Yes" answers in Section D and please remember to sign and date it.

| Q # | Person | Condition | Dates From / To | Hospitalized Yes / No | Surgery Yes / No | Treatment / Medication | Current Medication / Remaining Problems | Names and Addresses of Physicians and Hospitals |
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**Employee/Retiree Name** ____________________________________ **SSN or OEB-ID** ________________________________

## Section E: 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, the above statements and answers, and all written, telephonic and electronic information I have provided in support of my Application is complete, true and correctly recorded. I agree that they shall be the basis of the issuance of insurance for me and/or my dependents, if applicable, under the Group Policies. Further, I understand that, except where specifically provided in the Group Policies, Fort Dearborn Life Insurance Company (FDL) and Blue Cross and Blue Shield of Texas (BCBSTX), which are herein collectively called the Company, and/or The University of Texas 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 that insurance subject to medical questions requires approval by the Company, and additional medical information, including blood work, may be required to approve such insurance. I also understand that I am responsible to report to the Company's medical underwriting department any change in my health or that of my dependents, if applicable, prior to the date of approval of this Application, and that coverage will not become effective until the Company approves my Application, provided that I am actively at work on that date.
I understand and agree that:

- This authorization is voluntary and that my signature is required in order for the Company 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, the Company has the right to deny my request for coverage or that of my dependents, 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 the Company 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;
- 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 the Company.

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

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, HMO, employer, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's underwriting department, its authorized representative(s) or reinsurers, any information relating to me or my dependents concerning medical history, prescriptions, advice, care, or treatment, including any claims processed by BCBSTX, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness or physical condition, HIV (AIDS Virus) or other sexually transmitted diseases.
**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.

**X**__________________________________________ _______________ (___)_____________ (___)______________
Signature of Employee/Retiree | Date (mm/dd/yyyy) | Daytime Phone | Evening Phone

**X**__________________________________________ _______________ (___)_____________ (___)______________
Signature of Spouse (if requesting insurance) | Date (mm/dd/yyyy) | Daytime Phone | Evening Phone

**X**________________________________________________________ ________________________
Signature of Dependent – age 18 and older (if requesting insurance) | Date (mm/dd/yyyy)

**X**________________________________________________________ ________________________
Signature of Dependent – age 18 and older (if requesting insurance) | Date (mm/dd/yyyy)

**X**________________________________________________________ ________________________
Signature of Dependent – age 18 and older (if requesting insurance) | Date (mm/dd/yyyy)

***Remember:*** You must complete this application in its entirety to be considered for coverage. Return this application to:
Fort Dearborn Life Insurance Co. Administrative Offices, Attn: Medical Underwriting Dept. P.O. Box 655403 Dallas, Texas 75265-5403

**A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association*