

The University of Texas System
Evidence of Insurability Application (EOI)
for Voluntary Group Term Life Insurance (VGTL)



FORT DEARBORN LIFE INSURANCE COMPANY (FDL)

- Check the type of change requested:
- Annual Enrollment Change
 - Change of Status Event
 - New Hire
 - Retired Employee Increase

PLEASE RETURN THIS APPLICATION TO YOUR CAMPUS BENEFITS OFFICE 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: TO BE COMPLETED BY THE EMPLOYEE OR RETIRED EMPLOYEE

Check the appropriate UT System component from which you are employed or retired.

<input type="checkbox"/> 714 UT - Arlington	<input type="checkbox"/> 721 UT - Austin	<input type="checkbox"/> 747 UT - Brownsville	<input type="checkbox"/> 738 UT - Dallas	<input type="checkbox"/> 724 UT - El Paso	<input type="checkbox"/> 736 UT - Pan American	
<input type="checkbox"/> 742 UT - Permian Basin	<input type="checkbox"/> 743 UT - San Antonio	<input type="checkbox"/> 750 UT - Tyler	<input type="checkbox"/> 744 UT - HSC - Houston	<input type="checkbox"/> 745 UT - HSC - San Antonio		
<input type="checkbox"/> 785 UT - HC - Tyler	<input type="checkbox"/> 723 UT - M B - Galveston	<input type="checkbox"/> 506 UT - MD Anderson	<input type="checkbox"/> 729 UT - Southwestern	<input type="checkbox"/> 720 UT - System Administration		
Social Security No.	<input type="checkbox"/> Employee <input type="checkbox"/> Retired Employee Name: Last, First, MI	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	Base Annual Earnings	Daytime Phone ()	Evening Phone ()	Email Address		
*Employee VGTL Coverage Amount Requested: <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x Earnings			Employee's Current Coverage Amount: \$ _____			
Retired Employee VGTL Coverage Amount Requested: <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000						

Section B: TO BE COMPLETED ONLY BY THE SPOUSE OF AN ACTIVE EMPLOYEE (if requesting insurance)

Social Security No.	Spouse Name: Last, First, MI	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				
*Spouse VGTL Coverage Amount Requested: <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$40,000			Spouse's Current Coverage Amount: \$ _____			

***See the FDL Enrollment Guide for Guaranteed Coverage and EOI requirement information.**

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

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 the questions below? Check either "Yes" or "No" to each question, circle the specific condition, and give details at the end of this section.	Employee/Retired Employee		Spouse	
	Yes	No	Yes	No
1. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign or malignant)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Alcohol and/or drug addiction and/or substance abuse/treatment, mental, emotional or any other nervous disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Is there a current use of prescribed medications or use in the last 6 months?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions 1 through 6?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Any surgical operation performed or been advised to have any performed?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. 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 10?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Explanation of "Yes" answers in Section C

If the answer is "Yes" to any of the conditions in Section C, 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 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 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/Retired Employee.

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, 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, 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/Retired Employee

Date

Signature of Spouse (if requesting insurance)

Date

Remember: You must complete this application in its entirety to be considered for coverage. Return this application to your Campus Benefits Office.