RESET

Statement of Insurability for Disability Insurance
Instructions

1. **Employer's Name, Group #, Location/Division/Sub Group #, Class # (if applicable)**
   To be prefilled by your Employer. Any questions or concerns, please contact your Benefits Administrator.

2. **Employee Information:** Please complete information in full. If not requesting coverage, please leave blank.

3. **Product(s) Being Underwritten:** This section must be completed in order to process the request for coverage. This
   section refers to the type(s) of coverage you are requesting at this time.

4. **Completing personal information on the form.** All questions must be answered for each individual applying for coverage. All health questions answered yes must include details of the individual's medical history where asked. If this information is missing or incomplete, the application may be returned to you for completion.

5. **Signature(s) and date(s).** The signature and sign date must be completed on the bottom of the Statement for Insurability form where specified. Forms with this information missing will be returned, which will delay your request for coverage.

6. **For your records.** Please make a copy of the completed form for your records. The Insurance Information Practices Notice should be reviewed and kept by you for your records. for

7. **IMPORTANT! Submitting the form.** After completing, signing and dating the form, please mail, fax or email directly to the insurance company, please see below:

   UnitedHealthcare
   Group Medical Underwriting Services
   P.O. Box 17829
   Portland, ME 04112

   Fax #: 1-855-290-5224
   Email: eoi_underwriting@uhc.com

UnitedHealthcare Insurance Company
Statement of Insurability

Employer		Group #	Location
Employee Name		Employee Social Security No.	
Address		City, State, Zip	
Employee Date of Birth	Hire Date	Home Phone #	Work Phone #

Income
☐ Salaried Annual base salary ☐ Hourly Hourly rate # of hours worked per week

Persons Proposed for Coverage

NAME FIRST, M.I., LAST	SEX M/F	BIRTH DATE MM/DD/YYYY	HEIGHT FT, IN	WEIGHT LBS

Products(s) Being Underwritten

Short Term Disability ☐ Yes ☐ No	Long Term Disability ☐ Yes ☐ No

This Statement of Insurability is being submitted due to: ☐ Initial Enrollment ☐ Late Entrant ☐ Employer Open Enrollment ☐ Increase ☐ Other. If other, please explain: _____

The following questions apply to all persons proposed for coverage:

1. To the best of your knowledge, within the past 5 years has any person proposed for coverage ever been diagnosed or treated by a medical professional for any of the following:

☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Transient Ischemic Attack(TIA)
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Persistent hoarseness or cough
☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Heart Palpitations
☐ Yes ☐ No	Allergies	☐ Yes ☐ No	Stomach or duodenal ulcer	☐ Yes ☐ No	Cancer of any kind
☐ Yes ☐ No	Colitis	☐ Yes ☐ No	Varicose ulcers	☐ Yes ☐ No	Gout
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Tremors	☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Chest pain	☐ Yes ☐ No	Hernia of any kind	☐ Yes ☐ No	Cysts
☐ Yes ☐ No	Varicose veins	☐ Yes ☐ No	Circulatory system disease	☐ Yes ☐ No	Anemia
☐ Yes ☐ No	Depression	☐ Yes ☐ No	Sciatica	☐ Yes ☐ No	Headaches
☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Carpal tunnel syndrome	☐ Yes ☐ No	Bronchitis
☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Abnormal menstrual period	☐ Yes ☐ No	Phlebitis
☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Albumin or blood in the urine
☐ Yes ☐ No	Angina	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Hay fever
☐ Yes ☐ No	Lesions	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No	Loss of Hearing

☐ Yes ☐ No Heart disease, including but limited to Rheumatic heart disease, Ischemic Heart Disease or Inflammatory Heart Disease
☐ Yes ☐ No Bone disease, including but limited to osteoporosis, Paget's Disease of Bone or Osteonecrosis
☐ Yes ☐ No Lung disease, including but limited to Pneumonia, Emphysema or Chronic Obstructive Pulmonary Disease (COPD)
☐ Yes ☐ No Kidney disease, including but limited to End-stage Renal Disease or Polycystic Kidney disease
☐ Yes ☐ No Chronic pain condition, including but limited to Multiple Sclerosis, Fibromyalgia or Nerve damage (neuropathy)
☐ Yes ☐ No Connective tissue disease, including but limited to Marfan syndrome, Rheumatoid arthritis or Epidermolysis bullosa
☐ Yes ☐ No Liver disease, including but limited to Hepatitis, fatty liver or Cirrhosis
☐ Yes ☐ No Urinary bladder disease, including but limited to cystitis, bladder rupture and bladder obstruction (tamponade)
☐ Yes ☐ No Stomach or intestine disease, including but limited to Ulcerative colitis, Gastritis, Gastroparesis or Crohn's disease
☐ Yes ☐ No Tumor, disease, dysfunction of the reproductive organs, including but not limited to Dysmenorrhoea or Cancer of the Testis
☐ Yes ☐ No Alcoholism, narcotic addiction (or have you or your dependents joined any organization for alcoholism or drug abuse)
☐ Yes ☐ No Nervous or mental disorder (including professional counseling)
☐ Yes ☐ No Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)? Do not include HIV positive test results

2. Has any person proposed for coverage:
   a) ☐ Yes ☐ No Had any life or health insurance declined (not applicable to Missouri residents), postponed or modified, or had a waiver or extra premium added? If life or health insurance was declined, list the reason for the declination: _____
   b) ☐ Yes ☐ No Been released from the military for medical reasons?
   c) ☐ Yes ☐ No Received payment for disability, illness or injury?
   d) ☐ Yes ☐ No Had a change of weight of more than 10 pounds in the last 12 months? If Yes, state name of person(s), reason(s) and amount(s) of gain/loss in Detail Section below.
3. Within the past 5 years, has any person proposed for coverage:
   a) ☐ Yes ☐ No Had inpatient or outpatient surgery?
   b) ☐ Yes ☐ No Been advised by a medical professional to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test?
4. ☐ Yes ☐ No Have medications been prescribed to any person proposed for coverage for any reason in the last 12 months? If Yes, please list medication name, dose, dates used and condition used for in Detail Section below.
5. ☐ Yes ☐ No Are any persons to be covered pregnant?

   If Yes: Name of person_____.

   Expected delivery date:_____

DETAIL SECTION - GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 1 – 4 ABOVE IF MORE SPACE IS NEEDED, ATTACH A SEPARATE PIECE OF PAPER, SIGNED AND DATED.

Name of Person	Question No.	Dates of Treatment	Diagnosis, Degree of recovery	Name, Address, Phone # of Attending

NAME, ADDRESS AND PHONE # OF PRIMARY CARE PHYSICIAN OF PERSONS PROPOSED FOR COVERAGE:

	EMPLOYEE	SPOUSE	CHILDREN
DOCTOR NAME			
STREET ADDRESS			
CITY, STATE, ZIP			
PHONE NUMBER			

AUTHORIZATION AND ACKNOWLEDGEMENT

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response, to the best of my knowledge, will be complete and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; that has any medical, claim or benefit records which will be used to determine my eligibility for benefits to disclose that information to: the UnitedHealthcare Insurance Company; and, its affiliates ("UnitedHealthcare"). The information collected will be used to determine my eligibility for benefits.

I authorize UnitedHealthcare to: obtain; use; and disclose; my medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize UnitedHealthcare to disclose the information to the Policy's administrator; or as may be required by law. I authorize UnitedHealthcare, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original. I understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of the authorization.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying UnitedHealthcare in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right UnitedHealthcare has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires 24 months after the date it is signed. I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

I request the indicated group coverage for myself and, if applicable, for my dependents. I have not given the agent; or, any other persons any health information not included on this form. I understand that UnitedHealthcare is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; this completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that coverage will not take effect until UnitedHealthcare grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with this application.

NOTICES: (Please review notice that applies in your state)

For applicants in CALIFORNIA:

The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by us.

For residents of the following States:

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Alabama:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in Connecticut:

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For applicants in Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kansas:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of fraud as determined by a court of law.

For applicants in Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For applicants in Maine:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For applicants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in New Mexico:

Any person, who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

For applicants in Ohio:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For applicants in Oklahoma:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in Oregon:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or 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.

For applicants in Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For applicants in Virginia:

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may have violated state law.

For applicants in Tennessee and Washington:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For applicants in all other states:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature_____ Date _____

Return form to:
UnitedHealthcare Insurance Company
Group Medical Underwriting Services
PO Box 17829
Portland ME 04112-8829

Fax: 1-855-290-5224
Email: eoi_underwriting@uhc.com