Evidence of Insurability Instructions

The following application must be completed for employees who elect coverage requiring evidence of insurability.

Applications can be submitted

For paper submission, the following application must be submitted.

- Save this form to your computer and type responses directly into the document.
- If completing this form by hand, please print clearly and use black ink.
- All sections of the form must be complete.
- Read the Notice of Information Practices at the end of the form.
- Print, sign and date the form.
- If this form is not completed in its entirety and signed and dated, it will be returned unprocessed for your completion.
- Save a copy for your records.
- Submit the original, not including this page:
    - **To expedite processing, please fax your form to (secure number).**
    - Your form can also be mailed to:
      LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
      GROUP MEDICAL UNDERWRITING P.O. BOX 1525
      DOVER, NH 03821-1525

Note: Additional medical information may be required to process your application. If this is the case, you will be contacted by mail.

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LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
EVIDENCE OF INSURABILITY (EOI)
For Group Disability Insurance

1. CUSTOMER INFORMATION
Employer Information:

Customer Number	Customer Name	Location

Street Address	City	State	Zip Code

2. EMPLOYEE INFORMATION

Application Reason – pick the first reason that applies

- ☐ New employee electing benefits for first time — Date of hire:____________(mm/dd/yyyy)
- ☐ Existing employee newly eligible for benefits — Date employee eligible for benefits applied for: ____________(mm/dd/yyyy)
- ☐ Life/Family Status Change — Date of event: ____________(mm/dd/yyyy)
- ☐ Updating benefits outside enrollment period
- ☐ Updating benefits during enrollment period

Coverage(s) subject to Evidence of Insurability

☐ Long Term Disability ☐ Short Term Disability

3. APPLICANT INFORMATION

Name (Last, First, MI)	Social Security # 000-00-0000	Date of Birth (mm/dd/yyyy)	Birthplace (City, State, Country)	Gender M/F	Height (feet, inches)	Weight (lbs)
					,	

If you changed your name in the past 5 years, list former name(s) below:

Applicant's Current Name	Former Name

Employee's Residential Address:

Street Address	Apt. #	P.O. Box	City	State	Zip Code

Employee's Mailing Address (if different):

Street Address	Apt. #	P.O. Box	City	State	Zip Code

4. QUALIFYING INFORMATION

Please answer the following questions to the best of your knowledge and belief:

	Question	Answer
1.	During the past 3 years, have you been hospitalized, diagnosed, or treated by a medical professional for any disease, disorder, or condition other than annual exams and routine check-ups?	☐ Yes ☐ No
2.	Have you ever been diagnosed or treated by a medical professional or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No
3.	During the past 3 years, have you ever been prescribed medication other than for a cold, cough, allergies, or for birth control?	☐ Yes ☐ No
4.	Are you currently pregnant?	☐ Yes ☐ No
5.	Have you, during the past year, ever used any form of tobacco or nicotine products? If yes, indicate type of product and date last used in Section 5.	☐ Yes ☐ No
6.	Have you ever had any application for life, disability, or health insurance declined, postponed, or not approved as applied for?	☐ Yes ☐ No

If there are any "Yes" answers in Section 4, please complete Section 5. Otherwise, go to Section 6.

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5. DETAILS						
Question Number	Condition/ Diagnosis/Details	Treatments Received	Medications Prescribed	Date of Onset/ Date Medication First Prescribed (mm/yyyy)	Recovery Date, if applicable (mm/yyyy)	Name of Treating Health Professional(s)

6. DISCLOSURES AND SIGNATURES

AUTHORIZATION TO OBTAIN INFORMATION - I AUTHORIZE any medical practitioner, facility, or related entity, insurer, Medical Information Bureau, Inc. (MIB), reporting agency, or employer to give any medical, financial, or personal information about me or my family members to Liberty Life Assurance Company of Boston (the Company), any third party acting on its behalf and its reinsurers. This authorization applies to all types of information, including but not limited to information regarding HIV infection, AIDS, mental health, and substance abuse. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I AM AWARE that the Company will use this information to determine if I am eligible for insurance or benefits. I am aware that the Company may give this information to its reinsurers, MIB, other persons or entities that perform services related to my application or claim, or as may be authorized or required by law. Information obtained with my authorization may be re-disclosed as permitted or required by law and may no longer be protected by federal privacy laws. I AGREE that this authorization shall be valid for 2 years from the date I sign it. I UNDERSTAND that I have the right to revoke this authorization at any time by written notification to the Company at the address listed on page 1 of this document. I agree that a copy will be as valid as this original. I MAY ASK for a copy of this form. I HAVE READ the Notice of Information Practices and the notices required by the Federal Fair Credit Reporting Act and MIB.

Any person who knowingly presents a false statement in an Evidence of Insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

I have read the Evidence of Insurability and declare that all statements and answers given in this application are true and complete to the best of my knowledge and belief. I understand that the statements and answers will be used by the Company to determine insurability.

Employee signature (required at all times)	City/State where signed	Date signed (mm/dd/yyyy)

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NOTICE OF INFORMATION PRACTICES

To properly underwrite and administer your group coverage, we must collect a certain amount of necessary information. Your application is our most important source of information. However, we may collect additional information or verify application information by contacting: doctors of medical facilities which have provided care to you or to members of your family proposed for coverage. Additionally, a brief report may be made to the MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life and 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.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number 1-866-692-6901, TTY 866-346-3642, website address (www.mib.com).

We may also release information to other life insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report may contain information about your character, general reputation, personal characteristics and mode of living. You have the right to make a written request to us about the nature and scope of the investigative consumer report. Upon written request you will be told if a report was requested and the name, address and telephone number of the consumer reporting agency preparing the report. You may contact the consumer reporting agency and ask for a copy of the report. Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any information we acquire, will not be disclosed to third parties without your consent.

You have the right to see and copy items of personal information about you appearing in our files. You also have the right to seek correction, amendment or deletion of any information which you believe to be inaccurate or irrelevant.

You must make written request and allow 30 business days for disclosure of requested information. Our practice is to disclose the requested information to a medical professional designated by you since he/she will be able to best explain the information. In California and Massachusetts, we are able to disclose mental health record information directly to you only with the approval of the qualified professional with treatment responsibility for the condition to which the information relates.

We are not required to give you access to certain types of information. This information is usually collected in connection with a claim under an insurance policy or when the possibility of a lawsuit exists.

If you disagree with our records, you have the right to request a correction, amendment or deletion of any recorded personal information by written request which tells us what is incorrect and why. After we investigate and agree to the inaccuracy, we will proceed with the requested correction, amendment or deletion and notify anyone to whom we had provided the inaccurate information of its correction.

If we disagree, we will give you our reasons for refusing your request. If you are not satisfied, you have the right to send us a concise statement of what you believe is the correct information and why you disagree which we will place in our files, send a copy of to anyone to whom we had previously provided the disclosed information and include with any future disclosure of information from your file.

Under New Mexico law and to the extent we are providing insurance coverage, we are prohibited from using any confidential abuse information, obtained from any source, as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating, restricting or excluding coverage or benefits or charging a higher premium. You have a right to access and correct any confidential abuse information we receive. You may also request a more complete description of your rights. If you would like to be considered a protected person, please contact us at pstprivacy@libertymutual.com or 1-800-344-0197.

Please be assured that Liberty Mutual Insurance is committed to the careful handling of your personal information. If you wish to exercise any of the above rights or have additional questions, please write to the address shown on your application.

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