BlueCross BlueShield of Texas

The University of Texas System
Evidence of Insurability Information Form
Voluntary Group Term Life Insurance (VGTL), Short Term Disability and/or Long Term Disability

To be completed by the Employee/Retired Employee:

- ☐ **New Hire (Date _____)**
- ☐ **Annual Enrollment Change**
- ☐ **Qualified Change in Status Event**
  - **(Date of Event _____)**
  - **(Reason _____)**

REMEMBER: You must complete each page in full, and the application must be signed and dated on Page 4 to be considered. Please complete this application in black or blue ink.

Return this application to:
Blue Cross and Blue Shield of Texas
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515
Phone Number: (866) 628-2606
Fax Number: (855) 691-7157

This form cannot be considered unless received by Blue Cross and Blue Shield of Texas (BCBSTX) within 30 days following the end of your initial eligibility period, a qualified change in status event, or if applying during Annual Enrollment within 15 days of the close of Annual Enrollment. Insurance that requires satisfactory evidence of good health will not be effective for an applicant unless, and until, BCBSTX accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days. **Do NOT apply for the UT SELECT Medical plan on this application, as evidence of insurability is not required to enroll in the UT SELECT Medical plan. Please contact your institution Benefits Office if you have any questions about enrollment in the UT SELECT Medical plan.**

You are applying for (Check all that apply and please do NOT reapply for existing coverage):

☐ **Voluntary Group Term Life** ☐ **Short Term Disability** ☐ **Long Term Disability**

Section A: EMPLOYEE/RETIRED EMPLOYEE DATA

Check the appropriate UT System Institution from which you are employed or retired:

☐ 714 U.T. Arlington	☐ 724 U.T. El Paso	☐ 750 U.T. Tyler
☐ 721 U.T. Austin	☐ 746 U.T. Rio Grande Valley	☐ 506 U.T. M.D. Anderson Cancer Ctr Houston
☐ 785 U.T. HSC Tyler	☐ 742 U.T. Permian Basin	☐ 723 U.T. Medical Branch Galveston
☐ 744 U.T. HSC Houston	☐ 738 U.T. Dallas	☐ 729 U.T. Southwestern Medical Ctr Dallas
☐ 743 U.T. San Antonio	☐ 745 U.T. HSC San Antonio	☐ 720 U.T. System Administration Austin
		☐ 755 Stephen F. Austin State University

Social Security No. or Benefits ID	☐ Employee ☐ Retired Employee Name: Last First MI	Employee Basic Annual Earnings:

Section B: REQUESTED COVERAGE (Please do NOT reapply for existing coverage)

VOLUNTARY GROUP TERM LIFE INSURANCE (VGTL)

	Current Coverage Amount	Check the Total Coverage(s) you are applying for:
Employee VGTL Coverage	$ _____	☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x ☐ 7x ☐ 8x ☐ 9x ☐ 10x Earnings
Voluntary Spouse GTL Coverage	$ _____	☐ $15,000 ☐ $40,000
Retired Employee VGTL Coverage	$ _____	☐ $7,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000
Retired Employee's Spouse VGTL Coverage	$ _____	☐ $3,000

DISABILITY INSURANCE (Employees only) (Please do NOT reapply for existing coverage)

☐ **Short Term Disability** ☐ **Long Term Disability**

Section C: SPOUSE DATA to be completed for a spouse applying for VGTL Insurance

(Please do NOT reapply for existing coverage)

Relationship to Employee or Retired Employee	Name: Last First MI
Spouse	

R081024 I Z4306_ut

Dearborn Life Insurance Company

Evidence of Insurability Application

To be completed by the applicant
Return completed application and enrollment information to:

Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (866) 628-2606
Fax Number: (855) 691-7157

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION TO BE CONSIDERED FOR COVERAGE.
Retain a copy of this application for your records.

EMPLOYEE INFORMATION SECTION: (Complete even if Employee is not applying for coverage.)					
Name First MI Last			□ Male □ Female	Date of Birth (MM/DD/YYYY)	
Social Security Number	Alternate ID	State of Birth	Country of Birth		
Home Mailing Address Street			City	State	Zip Code
Preferred Method of Contact	Employee Telephone Number		Cell Phone Number		
Work Phone Number	Email Address		Occupation		

SPOUSE INFORMATION SECTION: (Complete only if applying for Spouse coverage.)			
Name First MI Last		□ Male □ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Preferred Method of Contact	Spouse Telephone Number	Cell Phone Number
Work Phone Number	Email Address	State of Birth	Country of Birth

Dearborn Life Insurance Company

Evidence of Insurability Application

To be completed by the applicant
Return completed application and enrollment information to:

Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (866) 628-2606
Fax Number: (855) 691-7157

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION TO BE CONSIDERED FOR COVERAGE.
Retain a copy of this application for your records.

Employee Name _____ Social Security Number _____

HEALTH INFORMATION – Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "Yes" answers must be provided in section provided on page 3 below for any person applying for coverage. Omitted information will cause consideration of coverage to be delayed. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.

HEALTH QUESTIONS SECTION: (Complete only if applying for coverage.)

1. Employee Height _____ feet _____ in. Weight ____ lbs. Spouse Height ____ feet ____ in. Weight ____lbs.
2. **In the past 7 years,** has any person applying for coverage been diagnosed, treated, or given medical advice by a physician or other medical professional for:

	Employee		Spouse	
	Yes	No	Yes	No
a. Congestive heart failure, heart attack, stroke, paralysis, cirrhosis of the liver, Hepatitis (B or C), emphysema, or chronic obstructive pulmonary disease (COPD):	□	□	□	□
b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the HIV virus:	□	□	□	□
c. Hodgkin's disease, leukemia, lymphoma, or malignant brain tumor?	□	□	□	□
d. Chronic kidney disease including failure, dialysis, transplant, or polycystic kidney disease?	□	□	□	□
e. Dementia, Alzheimer's disease, ALS (Lou Gehrig's Disease), Huntington's Chorea, multiple sclerosis, or muscular dystrophy?	□	□	□	□
f. Cancer, tumor, heart condition, high blood pressure, transient ischemic attack (TIA), aneurysm, neurological, or circulatory disorder?	□	□	□	□
g. Diabetes, systemic lupus, any autoimmune disorder, anemia or other blood disorder?	□	□	□	□
h. Gastrointestinal, respiratory, genitourinary, musculoskeletal, or connective tissue disorder?	□	□	□	□
i. Depression, anxiety, or any other mental/nervous disorder?	□	□	□	□
3. **In the past 5 years,** has any person applying for coverage received medical advice, sought treatment for drug or alcohol abuse, used any controlled substances (except those prescribed by a physician or other medical professional), been convicted or charged with operating a motor vehicle under the influence of drugs or alcohol?	□	□	□	□
4. **In the past 6 months**, has any person applying for coverage:				
a. been hospitalized, advised to have surgery, treatment, diagnostic tests, or other evaluation?	□	□	□	□
b. been prescribed long term maintenance medications for chronic conditions?	□	□	□	□
5. Has any person applying for coverage used cigarettes or other tobacco in the last 2 years?	□	□	□	□

EMPLOYEE HEALTH QUESTIONS SECTION: (Complete in addition to Health Questions Section above if applying for DISABILITY coverage.)

1. Are you pregnant? If "Yes", Date Due: _____ Any complications or problems? □ □
2. **In the past 7 years,** have you been diagnosed or treated by a member of the medical profession for a disorder of the back, spine, neck, knee, bone or joint, arthritis, neurological disorder, fibromyalgia, chronic fatigue syndrome, or other musculoskeletal disorder? □ □

Dearborn Life Insurance Company

Evidence of Insurability Application
To be completed by the applicant
Return completed application and enrollment information to:

Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (866) 628-2606
Fax Number: (855) 691-7157

Employee Name _____ Social Security Number _____

PROVIDE DETAILS OF ALL "YES" ANSWERS FROM ALL HEALTH QUESTION SECTIONS ABOVE (If applicable). If additional space is required, attach a separate signed and dated sheet.

#	Person	Type of Condition	Dates	Hospitalized Yes or No	Surgery Yes or No	Treatment/ Medication	Current Meds/ Remaining Problems	Physician's Name, Address & Phone #

Dearborn Life Insurance Company

Evidence of Insurability Application
To be completed by the applicant
Return completed application and enrollment information to:

Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (866) 628-2606
Fax Number: (855) 691-7157

AGREEMENTS AND AUTHORIZATION: "I" refers to the person(s) applying for insurance, signing below. I hereby represent that the statements and answers to the question(s) are, to the best of my knowledge and belief, full, complete, true and correctly recorded, and will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. I understand Dearborn Life Insurance Company shall not be liable for any claim arising prior to the date of approval of this application at Dearborn Life Insurance Company's Home Office.

To determine my eligibility for the coverages applied for, I authorize any physician, medical professional, practitioner, hospital, clinic, other health facility, medical or medically-related facility, medical provider, mental health professional, pharmacy or pharmacy benefit manager, laboratory, insurance company, the MIB, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn Life Insurance Company's underwriting department its authorized representative(s), my medical records, including information concerning advice, care or treatment for any condition, including but not limited to medical history, pharmaceutical history, drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize Dearborn Life Insurance Company to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB, Inc., a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.
This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time by written notice, but that such a revocation will have no effect on any actions taken by Dearborn Life Insurance Company prior to receipt of the revocation;
- Information provided pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule);
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- **Coverage will not become effective until Dearborn Life Insurance Company approves my application, provided that I am actively at work on that day;**
- **No premiums may be deducted by my Employer on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by my employer from Dearborn Life Insurance Company.**

I, as well as any other 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 Dearborn Life Insurance Company.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, Dearborn Life Insurance Company has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

Signature of Employee (required) _____ Date Signed (MM/DD/YYYY) _____

Signature of Spouse (if requesting insurance) _____ Date Signed (MM/DD/YYYY) _____

BlueCross BlueShield of Texas

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

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.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who 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.

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.

Ohio: Any person who, with intent to defraud or knowingly 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.

Oklahoma: 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 is guilty of a felony.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: 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.

Tennessee: 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.

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.

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

R010122 I Z6291_LC_BCBSTX

The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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.

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

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

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.