Group Life Insurance Evidence of Insurability

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: Fairfax County Public Schools **POLICY NUMBER: 27515**

1. Always complete sections A and G.
2. And if you are electing coverage on your dependents, complete sections C and/or D.
3. And if you are electing any coverage that according to your plan design is not guaranteed, complete sections E and F.

A. EMPLOYEE INFORMATION

First name	Middle initial	Last name	
Street address	City	State	Zip code
Date of birth	Social Security number	Date of employment	Gender ☐ Male ☐ Female

B. REPLACEMENT INSURANCE INFORMATION

☐ Yes
☐ No
Not Applicable Is the insurance you are applying for replace or change an existing policy? If yes, please complete the replacement form.

C. SPOUSE INFORMATION

First name	Middle initial	Last name
Date of birth	Social Security number	Gender ☐ Male ☐ Female

D. CHILDREN INFORMATION - (list names and dates of birth for your eligible children)

E. HEALTH QUESTIONS - (must be answered for coverage that is not guaranteed)

Employee		Spouse		Children		Employee		Spouse		
Yes	No	Yes	No	Yes	No	Height	Weight	Height	Weight	Occupation
☐	☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐	☐					

1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
3. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

If you answer yes to any question, give details including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment in the Additional Health Information Section below or on a separate sheet of paper.

F. ADDITIONAL HEALTH INFORMATION

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or your rights, you may contact:

Group Division Underwriting
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
MIB Telephone: (866) 692-6901
MIB TTY: (866) 346-3642
Website: www.mib.com

G. AUTHORIZATION

The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage.

To determine my insurability, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, medical and support staff of the Company. For purposes of determining my insurability, this authorization is valid for 24 months from the date I sign it.

For claims purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to claims staff of the Company. For claims purposes, this authorization is valid for 24 months or the duration of a claim, whichever is less. If coverage is rescinded due to false or incorrect answers to the above questions, an otherwise valid claim will be denied.

A photocopy of this authorization shall be as valid as the original. I have read this and the Consumer Privacy Notice and I understand that I or my authorized representative can have copies.

Employee signature	Daytime telephone number	Evening telephone number	Date signed
X			
Spouse signature	Daytime telephone number	Evening telephone number	Date signed
X			
Agent/broker/registered representative **Not Applicable**	Agent: To the best of my knowledge and belief, will the insurance applied for replace or change an existing policy? ☐ YES ☐ NO **Not Applicable**		
Agent's signature X **Not Applicable**			Date signed **Not Applicable**

FOR HOME OFFICE USE ONLY: **POLICY NUMBER: 27515**

Employee		Spouse		Children	
Current in force $	U/W applied for $	Current in force $	U/W applied for $	Current in force $	U/W applied for $
☐ Approved ☐ Declined ☐ Incomplete		☐ Approved ☐ Declined ☐ Incomplete		☐ Approved ☐ Declined ☐ Incomplete	
By	Date	By	Date	By	Date