

Group Life Insurance Evidence of Insurability



Minnesota Life Insurance Company - a Securian Financial company
 Administered by Ochs, Inc. • 18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025
 1-800-392-7295 • Fax 651-665-3791

EMPLOYER NAME:

POLICY NUMBER:

EMPLOYEE INFORMATION

Name (first, middle initial, last)	Date of birth	Phone number
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Address (street, city, state, zip)

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Annual salary	Date of employment
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Total amount of insurance requested \$	Email address
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SPOUSE INFORMATION (only complete if coverage requires evidence of insurability)

Name (first, middle initial, last)	Date of birth	Phone number
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Address (street, city, state, zip; check here if same as above)

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Email address
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Total amount of insurance requested \$

CHILDREN INFORMATION (only complete if coverage requires evidence of insurability)

Name	Date of birth	Name	Date of birth	Total amount of insurance requested \$

HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee height	Employee weight	Spouse height	Spouse weight	Spouse occupation
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Employee Yes No	Spouse Yes No	Children Yes No	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	1. In the last 7 years have you been diagnosed or treated for any of the following: <ul style="list-style-type: none"> • Heart disease or disorder, chest pain • High blood pressure • Cancer or tumor • COPD, sleep apnea or other lung or respiratory disease • Stroke, TIA, seizure, epilepsy, or multiple sclerosis • Kidney or pancreas disorder • Ulcerative Colitis, Crohn's disease, bariatric surgery, or any stomach or intestinal disorder • Anemia, leukemia, or other blood disorder • Hepatitis B, Hepatitis C, or other liver disorder • Diabetes • Depression, bipolar disorder, or any mental disorder • Drug or alcohol misuse including addiction • Chronic pain, rheumatoid arthritis, psoriatic arthritis, lupus • AIDS, AIDS Related Complex, or HIV, including positive test results • ALS or muscular dystrophy
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	2. During the past 5 years, have you, for any reason other than the conditions in question 1, been hospitalized, had surgery, received medication, treatment or diagnostic testing (other than: acid reflux; allergies; birth control; high cholesterol; cold; appendix or gallbladder removal; underactive thyroid; kidney stones; pregnancy without complications; or minor infection)?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	3. Are any future inpatient or outpatient medical, surgical, or diagnostic procedures recommended or being considered by a medical professional (other than: routine lab testing or physical)?

Securian Financial is the marketing name for Minnesota Life Insurance Company. Insurance products are issued by Minnesota Life Insurance Company.

⇨⇨⇨⇨⇨ **Please provide details to all "Yes" answers on page 2 and sign page 3** ⇨⇨⇨⇨⇨

EMPLOYER NAME:

POLICY NUMBER:

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, data aggregator, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. 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, Inc., to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. HIV-related information may not be released after 180 days from the date this Authorization is signed. Disclosure of HIV test results pertaining to my application for insurance is governed by A.R.S. 20-448.01. A copy of this Authorization is as valid as the original. I understand I or my authorized representative is entitled to receive a copy of this Authorization. I understand the information may be used for the purpose of performing actuarial or internal business studies, research, analytics and other analysis. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest the policy. In the case of an Authorization signed for the purpose of collecting information in connection with a claim for benefits under the policy, this Authorization shall be no longer than the term of coverage of the policy if the claim is for a health insurance benefit or the duration of the claim if the claim is not for a health insurance benefit. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I have read this Authorization and Consumer Privacy Notice and I understand I can have copies. 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 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 authorize my employer to withdraw premiums from my salary to pay for this coverage. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee signature X	Date signed	Employee name (please print)	Date of birth
Spouse signature X	Date signed	Spouse name (please print)	Date of birth
Children (age 18 and older) signature X	Date signed	Children name (please print)	Date of birth

FOR OFFICE USE ONLY:

Employee		Spouse		Children		Dependent Life Package - Coverage Code 94	
Current in force	U/W applied for	Current in force	U/W applied for	Current in force	U/W applied for	U/W applied for spouse	U/W applied for child
\$	\$	\$	\$	\$	\$	\$	\$