

# Statement of Insurability Instructions

## Employee Basic Life Insurance

1. **When to complete this form.**

- Within 30 days of first becoming eligible for Basic Life Insurance and the amount you are requesting is over the Guarantee Issue maximum for your Employer's plan
- If applying for Basic Life Insurance after 30 days of first becoming eligible for Basic Life Insurance, regardless of amount you are requesting.
- If requesting an increase to your existing Basic Life Insurance amount.

2. **Complete the form titled Employee Basic Life Insurance**

Product(s) being Underwritten section: Basic Life insurance coverage for the employee only.  
Reason Statement of Insurability is being submitted. Based on the Employees status.  
Phone Number

3. **Complete the Employee Information Section**

This information is required in order to process the request for coverage. If this information is missing or incomplete it will delay your request for coverage

Employee Name	Height
Employee Social Security Number	Weight
Date of Birth	Salary (Amount and indicate weekly, monthly, annual)
Home address	Job Title
City, State, Zip	Employment Date (date of hire)
Sex	

If your employer hasn't already completed the information below, please obtain the correct information from your Benefits Administrator and fill it in on the form prior to submitting your request for coverage. If this information is missing or incomplete it will delay your request for coverage.

Employer Name	Group Policy Number
---------------	---------------------

4. **Complete ALL questions in the Medical History, Detail and Personal Physician Sections**

Disregard all references to dependents as they do not pertain to this request. It is important that ALL of the requested information be provided, including specific details to medical history, where asked. It's important to ONLY include medical information regarding the employee. If this information is missing or incomplete it will delay your request for coverage

5. **Signature and date.** The signature and sign date of employee applying for coverage must be completed on the bottom of the form where specified. We cannot process a request without this information. Forms with this information missing will be withdrawn and returned to the employee to be updated and resubmitted.

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.

7. **Submitting the form.** After completing, signing and dating the Statement of Insurability form, please mail the completed form to **United HealthCare Insurance Company, Mail Route MN012-N123, 5901 Lincoln Drive, Edina, MN 55436**

## Employee Basic Life Insurance

**To request coverage, complete the following sections, sign the form and submit it to United HealthCare Insurance Company, Mail Route MN012-N123, 5901 Lincoln Drive, Edina, MN 55436**

- PRODUCT BEING UNDERWRITTEN
- REASON FOR REQUEST
- EMPLOYEE INFORMATION
- MEDICAL HISTORY SECTION (Disregard reference to dependents as they don't pertain to your request)
- DETAIL SECTION (Disregard reference to dependents as they don't pertain to your request)
- NAME, ADDRESS AND PHONE NUMBER OF PERSONAL PHYSICIAN (Disregard reference to dependents as they don't pertain to your request)
- AUTHORIZATION AND ACKNOWLEDGEMENT/ SIGNATURE AND DATE

### PRODUCT BEING UNDERWRITTEN

EMPLOYEE COVERAGE	AMOUNT YOU ALREADY HAVE WITH EMPLOYER	AMOUNT YOU'RE REQUESTING (If increase, only include additional amount)	TOTAL AMOUNT OF CURRENT COVERAGE PLUS NEW REQUEST
Basic Life	\$	\$	\$

### REASON FOR REQUEST

This Statement of Insurability is being submitted due to:

- Initial Enrollment
- Late Entrant
- Employer Open Enrollment
- Increase
- Other. If other, please explain: \_\_\_\_\_

### PHONE NUMBER

Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

# United HealthCare Insurance Company

## Statement of Insurability

EMPLOYEE INFORMATION							
Last Name	First Name	M.I.	Social Security Number	Employer Assigned ID	Birthdate		
Street Address		Apt No.	City	State	Zip Code	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Height: ____ ft. ____ in.		Weight: _____ lbs		Salary (if applicable) \$ _____		<input type="checkbox"/> Wk	<input type="checkbox"/> Mo <input type="checkbox"/> Ann
Employer or Group Name			Policy Number	Job Title		Employment Date	

**MEDICAL HISTORY SECTION:** The health questions below pertain to you. They also apply to each eligible family member if you are applying for Dependent Coverage.

1. To the best of your knowledge and belief, in the past 10 years have any applicants for insurance been medically treated for or medically diagnosed with:

- a) Diagnosed with or taking medication to control hypertension (high blood pressure)?  Yes  No
- b) Seizure, paralysis, brain aneurysm, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease), polio, post-polio syndrome and/or degenerative conditions of the muscles and/or nerves?  Yes  No
- c) Heart attack, heart murmur, heart disease, disease of the heart valve(s), stroke, TIA (transient ischemic attack), heart related angina, chest pain, coronary artery disease, abnormal EKG, arrhythmia, pericarditis, cardiomyopathy, endocarditis, peripheral vascular disease, aneurysm, congenital heart defect or congenital heart disease?  Yes  No
- d) Emphysema, idiopathic pulmonary fibrosis, primary pulmonary hypertension, cystic fibrosis, or any other lung or respiratory disorder?  Yes  No
- e) Diabetes (not related to pregnancy), liver adenoma, hepatitis, cirrhosis, ulcer of the stomach or duodenum, colitis, or any other disorder of the stomach or intestines?  Yes  No
- f) Varicose veins, varicose ulcers, phlebitis or hernia of any kind?  Yes  No
- g) Kidney disease, polycystic kidneys, albumin or glucose in the urine, or any other urinary disorder, elevated PSA (prostate specific antigen), abnormal uterine bleeding, pap smear consistent with high grade SIL (squamous intraepithelial lesion), severe dysplasia or CIN III (cervical intraepithelial neoplasia), abnormal mammogram requiring or with recommendation of breast biopsy?  Yes  No
- h) Cancer, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, melanoma or pre-cancerous lesions/tumors?  Yes  No
- i) Arthritis, rheumatism or any musculoskeletal disorder or other disorder of the joints, muscles, back, spine or bones.  Yes  No
- j) Any disease or disorder of the eyes, ears, nose or throat?  Yes  No
- k) Alcoholism, drug dependency or substance abuse?  Yes  No
- l) Nervous, mental or emotional disorder, or has the applicant sought psychological or mental health counseling?  Yes  No
- m) Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?  Yes  No

2. Have you or your dependents, if applicable:

- a) Had any life or health insurance declined, postponed or modified, or had a waiver or extra premium added?  Yes  No
- b) Been released from the military for medical reasons?  Yes  No
- c) Received payment for disability, illness or injury?  Yes  No
- d) Had a change of weight of more than 10 pounds in the last 12 months, not due to normal growth?  Yes  No



# United HealthCare Insurance Company Insurance Information Practices Notice

## Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Statement of Insurability Form, and, if necessary, confirm or add to this information in the ways described in this notice.

## Privacy and Information Practices

### Collecting Information

**Your Statement of Insurability Form is our main source of information. But we may:**

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

### Information Use

**We will use the information only for business purposes arising from the relationship you have with us.**

### Information Maintenance and Disclosure

**We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with United HealthCare Insurance Company or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.**

### Access to Information

**If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.**

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

### Notice Regarding MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. United HealthCare Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112.

**United HealthCare Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.**