

### EVIDENCE OF INSURABILITY APPLICATION

#### UT SELECT Medical Plan and/or Voluntary Group Term Life Insurance (VGTL)

**REMEMBER: You must complete each page in full, and the application must be signed and dated on Page 3 to be considered. Please complete this application in black or blue ink. Return this application to:**

Fort Dearborn Life Insurance Company®  
 Administrative Offices, Attn: Medical Underwriting Dept.  
 P.O. Box 655403  
 Dallas, Texas 75265-5403

To be completed by the  
Employee/Retired Employee.

- Annual Enrollment Change
- Change in Status Event  
(Date of Event \_\_\_\_\_)
- New Hire
- Retired Employee Increase

This form cannot be considered unless received by FDL within 30 days of initial eligibility 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, FDL accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

You are applying for:     Medical     Life     Medical and Life

#### Section A: EMPLOYEE/RETIRED EMPLOYEE DATA

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

<input type="checkbox"/> 714 U. T. Arlington <input type="checkbox"/> 721 U. T. Austin <input type="checkbox"/> 747 U. T. Brownsville <input type="checkbox"/> 738 U. T. Dallas	<input type="checkbox"/> 724 U. T. El Paso <input type="checkbox"/> 736 U. T. Pan American <input type="checkbox"/> 742 U. T. Permian Basin <input type="checkbox"/> 743 U. T. San Antonio	<input type="checkbox"/> 750 U. T. Tyler <input type="checkbox"/> 785 U. T. HSC Tyler <input type="checkbox"/> 744 U. T. HSC Houston <input type="checkbox"/> 745 U. T. HSC San Antonio	<input type="checkbox"/> 506 U. T. M.D. Anderson Cancer Ctr Houston <input type="checkbox"/> 723 U. T. Medical Branch Galveston <input type="checkbox"/> 729 U. T. Southwestern Medical Ctr Dallas <input type="checkbox"/> 720 U. T. System Administration Austin
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Social Security No. or Benefits ID No.	<input type="checkbox"/> Employee <input type="checkbox"/> Retired Employee Name: Last                      First                      MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM    DD    YYYY /    /	Height Ft.    In. /	Weight Lbs.
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Home Mailing Address – Street	City	State	Zip
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Employee Basic Annual Earnings:	Email Address:
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#### Section B: REQUESTED COVERAGE

<u>UT SELECT MEDICAL PLAN</u> (Administered by Blue Cross and Blue Shield of Texas*)	<u>VOLUNTARY GROUP TERM LIFE INSURANCE (VGTL)</u> (Underwritten by Fort Dearborn Life Insurance Company)												
Check the coverage(s) you are applying for:  Employee / Retired Employee Cvg. <input type="checkbox"/>  Spouse Coverage <input type="checkbox"/>  Dependent Coverage <input type="checkbox"/>	<table style="width: 100%;"> <tr> <td style="width: 30%;">Current Cvg. Amt.</td> <td style="width: 40%;">Check the Total Coverage(s) you are applying for:</td> <td style="width: 30%;"></td> </tr> <tr> <td>Employee VGTL Coverage    \$ _____</td> <td><input type="checkbox"/> 1x   <input type="checkbox"/> 2x   <input type="checkbox"/> 3x   <input type="checkbox"/> 4x   <input type="checkbox"/> 5x   <input type="checkbox"/> 6x Earnings</td> <td></td> </tr> <tr> <td>Employee's Spouse VGTL Cvg. \$ _____</td> <td><input type="checkbox"/> \$25,000    <input type="checkbox"/> \$50,000</td> <td></td> </tr> <tr> <td>Retired Employee VGTL Cvg. \$ _____</td> <td><input type="checkbox"/> \$7,000    <input type="checkbox"/> \$10,000    <input type="checkbox"/> \$25,000    <input type="checkbox"/> \$50,000</td> <td></td> </tr> </table>	Current Cvg. Amt.	Check the Total Coverage(s) you are applying for:		Employee VGTL Coverage    \$ _____	<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x Earnings		Employee's Spouse VGTL Cvg. \$ _____	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		Retired Employee VGTL Cvg. \$ _____	<input type="checkbox"/> \$7,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	
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Employee VGTL Coverage    \$ _____	<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x Earnings												
Employee's Spouse VGTL Cvg. \$ _____	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000												
Retired Employee VGTL Cvg. \$ _____	<input type="checkbox"/> \$7,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000												

#### Section C: SPOUSE DATA to be completed for a spouse applying for the UT SELECT Medical Plan or VGTL Insurance OTHER DEPENDENT DATA to be completed *only if applying for the UT SELECT Medical Plan*

Relationship to Employee or Retired Employee	Name: Last                      First                      MI	Social Security No. or Benefits ID No.	Date of Birth MM / DD / YYYY	Height Ft. / In.	Weight Lbs.
<input type="checkbox"/> Spouse			/ /	/	
<input type="checkbox"/> Daughter <input type="checkbox"/> Son			/ /	/	
<input type="checkbox"/> Daughter <input type="checkbox"/> Son			/ /	/	
<input type="checkbox"/> Daughter <input type="checkbox"/> Son			/ /	/	
<input type="checkbox"/> Daughter <input type="checkbox"/> Son			/ /	/	
<input type="checkbox"/> Other Dependent(s) (specify)			/ /	/	

**NOTE: Please complete Form No. UT-EOI-App-08--Dep 2 for additional dependents and please remember to sign and date it.**

Employee/Retired Employee Name \_\_\_\_\_

SSN or Benefits ID No. \_\_\_\_\_

**Section D: HEALTH INFORMATION (Answer all questions fully and truthfully for any person applying for coverage.)**

Has any person applying for coverage been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in the questions below? Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "Yes" answers must be provided. Omission of any information may result in an adverse underwriting decision.	Employee or Retired Employee		Spouse		Dependent(s)	
	Yes	No	Yes	No	Yes	No
1. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign or malignant)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Alcohol and/or drug addiction and/or substance abuse/treatment, mental, emotional or any other nervous disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Is there a current use of prescribed medications or use in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions 1 through 6?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Any surgical operation performed or advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Is any person applying for coverage currently pregnant? If "Yes", indicate anticipated delivery date _____. Provide details of current/prior complications.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has any person applying for coverage been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions 1 through 11?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Explanation of "Yes" answers in Section D – Please provide details of "Yes" answers below. Please complete Form No. UT-EOI-App-08-Exp 2 for additional explanation/details of "Yes" answers in Section D and please remember to sign and date it.**

Q #	Person	Condition	Dates From / To	Hospitalized Yes / No	Surgery Yes / No	Treatment / Medication	Current Medication / Remaining Problems	Names and Addresses of Physicians and Hospitals

Employee/Retired Employee Name \_\_\_\_\_

SSN or Benefits ID No. \_\_\_\_\_

**Section E: AGREEMENTS AND AUTHORIZATION – Please read carefully before signing.**

I, the undersigned applicant(s), have read and agree that, to the best of my knowledge and belief, the above statements and answers, and all written, telephonic and electronic information I have provided in support of my Application is complete, true and correctly recorded. I agree that they shall be the basis of the issuance of insurance for me and/or my dependents, if applicable, under the Group Policies. Further, I understand that, except where specifically provided in the Group Policies, Fort Dearborn Life Insurance Company (FDL) and Blue Cross and Blue Shield of Texas (BCBSTX), which are herein collectively called the Company, and/or The University of Texas System shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to the date of approval of my request for insurance. I understand that insurance subject to medical questions requires approval by the Company, and additional medical information, including blood work, may be required to approve such insurance. I also understand that I am responsible to report to the Company's medical underwriting department any change in my health or that of my dependents, if applicable, prior to the date of approval of this Application, and that coverage will not become effective until the Company approves my Application, provided that I am actively at work on that date.

I understand and agree that:

- This authorization is voluntary and that my signature is required in order for the Company to consider this Application and to make a determination on whether to accept and issue the coverage(s) applied for herein;
- If I refuse to sign this authorization, the Company has the right to deny my request for coverage or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire 24 months from the date it is signed;
- All correspondence regarding coverage for those individuals listed on this Application will be sent to the Employee or Retired Employee.

I, as well as any 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 the Company.

If my answers on this Application are incorrect or untrue, or if I refuse to sign this authorization, the Company has the right to deny benefits or rescind my coverage or that of my dependents, if applicable, subject to the terms of the contract.

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, HMO, employer, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's underwriting department, its authorized representative(s) or reinsurers, any information relating to me or my dependents concerning medical history, prescriptions, advice, care, or treatment, including any claims processed by BCBSTX, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness or physical condition, HIV (AIDS Virus) or other sexually transmitted diseases.

**WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) 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.

<b>X</b> _____	_____	( ) _____	( ) _____
Signature of Employee/Retired Employee	Date Signed	Daytime Phone	Evening Phone

<b>X</b> _____	_____	( ) _____	( ) _____
Signature of Spouse (if requesting insurance)	Date Signed	Daytime Phone	Evening Phone

<b>X</b> _____	_____
Signature of Dependent – age 18 and older (if requesting insurance)	Date Signed

<b>X</b> _____	_____
Signature of Dependent – age 18 and older (if requesting insurance)	Date Signed

<b>X</b> _____	_____
Signature of Dependent – age 18 and older (if requesting insurance)	Date Signed

**Remember:** You must complete this application in its entirety to be considered for coverage. Return this application to: Fort Dearborn Life Insurance Co. Administrative Offices, Attn: Medical Underwriting Dept. P.O. Box 655403 Dallas, Texas 75265-5403

*\*A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association*