Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Evidence of Insurability (EOI)

Administrative Offices: **Downers Grove, Illinois I Dallas, Texas**

PART 1: TO BE COMPLETED BY GROUP ADMINISTRATOR/EMPLOYER (Please Print and submit with copy of employee enrollment form)

Group Number F022731

Group Name and Address

Lake Forest Academy
1500 W Kennedy Road
Lake Forest, IL 60045

Group Contact Kristin Paisley
(Print Name)

Group Contact Director of Business Services and HR
(Print Title)

Telephone (847) 615-3209

Fax (817) 810-1604

Reason for EOI:
- ☑ Amount over Guarantee Issue
- ☐ Late Enrollment
- ☐ Other _____

If New Hire, Indicate Eligibility Waiting Period
_____

Policy Anniversary Date
_____

FOR DEARBORN NATIONAL USE ONLY

EMPLOYEE	SPOUSE	CHILD(REN)
☐ Approved ☐ Declined ☐ Closed ☐ Smoker ☐ Nonsmoker	☐ Approved ☐ Declined ☐ Closed ☐ Smoker ☐ Nonsmoker	☐ Approved ☐ Declined ☐ Closed Amount Approved $_____ Effective Date* Reviewed by & date _____
GI ☐ No ☐ Yes $_____	GI ☐ No ☐ Yes $_____	
Amount Approved $_____ Effective Date* Reviewed by & date _____	Amount Approved $_____ Effective Date* Reviewed by & date _____	State Code _____ Agency (CB)(TPA) _____ ☐ SAWEB ☐ Self-Admin ☐ Direct Bill _____

* The effective date of coverage is the date the application is approved. Premium is due the first of the month following the approval date. **Do not deduct premiums for any coverage subject to evidence of insurability until you receive Dearborn National's final confirmation of approval.**

PART 2: TO BE COMPLETED BY EMPLOYEE - This section contains essential information and leaving any item blank will cause a delay in processing your insurance request.

EMPLOYEE

Name Last	First	M.I.	Date of Birth / /	Age	Sex ☐ M ☐ F	State of Birth

Home Mailing Address - Street	City	State	Zip	Work Telephone ( )	Home Telephone ( )

Social Security #	Height ft. in.	Weight lbs.

SPOUSE - DO NOT complete spouse information unless you are applying for dependent spouse coverage.

Name Last	First	M.I.	Date of Birth / /	Age	Sex ☐ M ☐ F	State of Birth

Social Security #	Height ft. in.	Weight lbs.

CHILD(REN) - DO NOT complete this section unless you are applying for dependent child(ren) life insurance which is subject to satisfactory evidence of insurability (for example, a late enrollment.) *Evidence of insurability is not required for voluntary** dependent child term life coverage.*

Dependent Child Full Name	SS#	Date of Birth	Age	Sex	Ht & Wt
				☐ M ☐ F	
				☐ M ☐ F	

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

**Evidence of Insurability is not required for supplemental or voluntary dependent child term life coverage for total benefit amounts of $10,000 or less.

Employee Name _____ Social Security #_____

Part 3: Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

Check either **"Yes"** or **"No"** to each question and **circle the specific condition(s). Details to all "yes" answers must be provided below. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.**	**Employee** Yes	No	**Spouse** Yes	No	**Child(ren)** Yes	No
1. Has any person applying for coverage been seen, treated, advised or received services from any health provider in the last 12 months, including routine physicals?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
2. Within the last 7 years, **has any person applying for coverage had symptoms, been diagnosed with and/or received treatment by/from a member of the health profession for any of the conditions listed in the questions below?**						
a. High blood pressure, heart attack, chest pain, shortness of breath, irregular heartbeat, murmur, coronary artery disease, heart surgery (catheterization/ angioplasty/bypass, etc.), or any other disease or disorder of the heart or circulatory system?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
b. Enlarged glands, thyroid disorder, diabetes, abnormal glucose level, hepatitis, cirrhosis, abnormal liver studies, hernia, ulcer, colitis or any other disease or disorder of the liver, endocrine, or digestive system?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia or any other mental/nervous/behavioral disorder?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
d. Asthma, emphysema, tuberculosis, pneumonia, COPD, sleep apnea, or any other disease or disorder of the throat, lungs, or respiratory tract?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
e. Prostate, uterus/tubes/ovaries, endometriosis, cystitis, kidney stone, renal failure, sexually transmitted diseases, any disorder of the kidneys/bladder/ urinary tract, breast lumps/changes/biopsies, abnormal test results or any other male/female disorder?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
f. Cancer, tumor, cyst, moles, polyps, growth or any skin disorder (indicate location and if benign/malignant)?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, or any other disease or disorder of the nervous system?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
h. Arthritis, gout, rheumatism, neck or back strain/sprain/injury, deformity, loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
3. 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?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
4. Does any person applying for coverage currently take medication (prescription or otherwise), been prescribed medication, or has any person done so in the last 6 months?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
5. Within the last 2 years, has any person applying for coverage had a physical disability, surgery, or been confined to a hospital, skilled nursing or rehabilitation facility, undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, MRI, CAT Scans, PET or CT Scans, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment; and/or been advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed, not mentioned in questions 1 through 3?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
6. Is any person applying for coverage currently pregnant? If **"Yes"**, indicate anticipated delivery date _____. **Provide details of any current/ prior complications on Page 3.**	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
7. Has any person applying for coverage *EVER HAD* symptoms, been diagnosed with, and/or received treatment from a member of the health profession for **ANY HEALTH CONDITION** other than those conditions listed above?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No

Employee Name _____ Social Security #_____

Part 3 (Continued): Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

	Employee Yes	Employee No	Spouse Yes	Spouse No	Child(ren) Yes	Child(ren) No
8. Has any person applying for coverage used cigarettes or other tobacco products in the last 2 years?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No
9. Has any person applying for coverage been rated, declined, postponed or limited in any way for life, health, accident or disability insurance?	❑Yes	❑No	❑Yes	❑No	❑Yes	❑No

PART 4: Provide details of all 'YES' answers given to questions in PART 3. – If additional space is required, attach a separate signed and dated sheet.

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

Employee Name _____ Social Security #_____

No premiums may be deducted on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by your employer from Dearborn National.

WARNING: 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. (Not enforceable in Oregon or Virginia.)

AGREEMENTS AND AUTHORIZATION: I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Dearborn National ®Life Insurance Company (Dearborn National) shall not be liable for any claim arising prior to the date of approval of this application at Dearborn National's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, clinic or other medical or medically-related facility, medical provider, the MIB Group, 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 National's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize Dearborn National to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB Group, Inc. a non-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, but that such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of 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 National approves my application, provided that I am actively at work on that day.

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 National.

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

_____ _____

Signature of Employee Date

_____ _____

Signature of Spouse (if requesting insurance) Date

_____ _____

Signature of Dependent Child (if to be insured and of age of majority) Date

(Please retain with your insurance records)

Thank you for enrolling for Group Insurance with Dearborn National® Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Dearborn National® Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

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

Dearborn National® Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file 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.

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

FOR APPLICATIONS AND CLAIMS:

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.

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

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.

Louisiana: 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.

Maine & 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.

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, with intent to injure, defraud or deceive any insurer, makes a 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

Virginia: 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.

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.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

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 or 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 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:

Massachusetts: 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.

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.