Group Life Insurance Evidence of Insurability

Minnesota Life Insurance Company - A Securian Company
Richmond Branch Office • PO Box 1193 • Richmond, VA 23218-1193 • Fax 804-644-2460

MINNESOTA LIFE

POLICYHOLDER NAME: Virginia Retirement System **POLICY NUMBER: 29414-G**

EMPLOYER NAME: _____ **EMPLOYER CODE:** _____

EMPLOYEE INFORMATION (must be completed)

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Street address	City	State	Zip code

Date of birth	Social Security number	Email address	Gender
			☐ Male ☐ Female

Total amount of insurance requested

☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4

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

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Date of birth	Social Security number	Email address	Gender
			☐ Male ☐ Female

CHILDREN INFORMATION (only complete if coverage requires evidence of insurability; list names and dates of birth)

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

Employee Yes	Employee No	Spouse Yes	Spouse No	Children Yes	Children No	
☐	☐	☐	☐	☐	☐	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)?

Employee Height	Employee Weight	Spouse Height	Spouse Weight

If you answer "Yes" to any question, please provide additional information below or on a separate sheet of paper.

ADDITIONAL HEALTH INFORMATION (provide details for every "Yes" answer to the health questions)

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

PLEASE READ & SIGN NEXT PAGE & SEND ALL PAGES TO MINNESOTA LIFE

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AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, 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 medical practitioner, insurance company or Medical Information Bureau (MIB), Department of Motor Vehicles or employer to give all medical or nonmedical information about me including alcohol or drug abuse, driving violations, association with criminal activiy, possible over insurance, foreign residencey or travel, aviation activity, hazardous occupational or sports activity 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 authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This 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.

I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. If I do not revoke this authorization, to determine my insurability it will be valid for 24 months from the date I sign it. For claims purposes, this authorization is valid for the duration of a claim. A copy of this Authorization is as valid as the original. I understand my authorized representative or I am entitled to receive a copy of this Authorization. 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 a claim under an insurance policy or to contest the policy itself. 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.

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. 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 business 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 the Company 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

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, subject to the Incontestability provision found in the policy or the certificate. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalities include imprisonment, fines and denial of insurance benefits.

Employee name (please print)

Employee signature	Date signed
X	

Spouse name (please print)

Spouse signature	Date signed
X	