Group Life Insurance
Evidence of Insurability Form

Underwritten by: United of Omaha Life Insurance Company Home Office: Omaha, Nebraska

Section 1: Employer Information (Please print clearly. Required fields are marked with an asterisk (*).)

Employer's Name*	**Group ID Number***
CNA Benefit Trust Group Insurance Policy	G000 1 8 2 J

Street Address	**Telephone** (xxx)xxx-xxxx
4610 Dublin Boulevard, Suite 400	(925)833-7300

City*	**State***	**ZIP Code**
Dublin	C A	94568-7756

Section 2: Employee Contact & Employment Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name*	**First Name***	**Middle Name**

Street Address*	**Email Address**

City*	**State***	**ZIP Code***	**Telephone*** (xxx)xxx-xxxx
	__ __		

Full-Time Employment Date (MM/DD/YYYY)*	**Job Title/Description***

Consent to Email Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this form via email.

Section 3: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee is Applying for Coverage

Birth Date (MM/DD/YYYY)*	**State of Birth***	**Gender***	**Weight***	**Height***	**Annual Salary***
	__ __	☐ Female ☐ Male	_____ Pounds	____ Ft. ____ In.	$

Part B – Complete if Your Eligible Dependent Spouse is Applying for Coverage

Last Name*	**First Name***	**MI**

Birth Date (MM/DD/YYYY)*	**State of Birth***	**Gender***	**Weight***	**Height***
	__ __	☐ Female ☐ Male	_____ Pounds	____ Ft. ____ In.

Note: Use of the term "spouse" on this form refers to the person to whom you are legally married, or your domestic partner or equivalent, as recognized and allowed by federal law, or by state law in your state of residence.

Part C – Complete for Any Eligible Dependent Children Applying for Coverage

Last Name*	**First Name***	**Gender***	**Birth Date** (MM/DD/YYYY)*	**Weight***	**Height***
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.

Section 4: Requested Coverage Amount (Please print clearly. Required fields are marked with an asterisk (*).)

	Employee (IF APPLICABLE)	**Spouse** (IF APPLICABLE)	**Each Child** (IF APPLICABLE)
(1) Current Amount of Insurance*			
(2) Additional Requested Amount*			
(3) Total Amount (1+2)*			

Section 5: Health Information for Applicants (Please print clearly. A response is required for each health question.)

Part A – Health Questions: Please answer questions 1 through 5 to the best of your knowledge and belief. If you respond "Yes" to any of these questions, please complete the Medication Information sheet on the next page.

Health Question 1	**Response**
Within the past five years have you been diagnosed or treated by a medical professional for, or had surgery for any of the following:	
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ YES ☐ NO
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), chronic pulmonary disease or cardio-pulmonary disease requiring oxygen?	☐ YES ☐ NO
C. Alzheimer's Disease, dementia or any other cognitive disease?	☐ YES ☐ NO
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	☐ YES ☐ NO
E. Systemic Lupus or Myasthenia Gravis?	☐ YES ☐ NO
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Please do not provide information regarding your HIV status.**	☐ YES ☐ NO
G. Chronic hepatitis or cirrhosis?	☐ YES ☐ NO
H. Osteoporosis with fractures?	☐ YES ☐ NO
Health Question 2	**Response***
Within the past five years been diagnosed or treated by a medical professional for diabetes?	☐ YES ☐ NO
Health Question 3	**Response***
Within the past five years been diagnosed or treated by a medical professional for:	
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ YES ☐ NO
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve, atrial fibrillation, abnormal heart rhythm, or implantation of a pacemaker?	☐ YES ☐ NO
C. High blood pressure / hypertension?	☐ YES ☐ NO
D. Alcoholism or drug abuse?	☐ YES ☐ NO
E. A mental or nervous disease requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ YES ☐ NO
F. Internal cancer, lymphoma or melanoma?	☐ YES ☐ NO
G. A stroke or transient ischemic attack (TIA)?	☐ YES ☐ NO
H. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis or arthritis that restricts mobility?	☐ YES ☐ NO
I. A joint replacement?	☐ YES ☐ NO
Health Question 4	**Response***
Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ YES ☐ NO
Health Question 5	**Response***
Have you taken any prescription drugs in the past 24 months?	☐ YES ☐ NO

Part B – Medical Information
If you responded YES to any Health Question under Part A on the previous page, you must provide the following, information, as applicable.

Ques. #	Name of Applicant	Date of Occurrence (MM/DD/YYYY)	Date of Recovery (MM/DD/YYYY)	Condition, Injury, Diagnosis, Prescription and/or Findings of Exam

Section 6: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

For your protection California law requires the following to appear on this form: 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.

Section 7: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 7

I or **me** means each person signing below in Part C of Section 7, except where otherwise noted.

MIB Group, Inc. (MIB) means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.

Personal Information means information about me and/or any dependent child applying for coverage, including health information medical history, mental and physical condition, drug and alcohol use, motor vehicle reports and criminal activity.

Part B – Authorization to Disclose Personal Information

To the MIB: I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company ("Mutual of Omaha") or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it.

Name(s) used for medical records (if different than the name(s) provided on this form): _____

_____

Part C – Application for Insurance

If I am an eligible employee applying for insurance, I apply for life insurance for me and any child who is has not yet attained age 18 identified in Section 3 of this form who is eligible for insurance. If I am an eligible child, age 18 or greater, of the employee applying for insurance, I apply for life insurance for me. If I am an eligible spouse of the employee applying for insurance, I apply for life insurance for me.

I understand that any insurance for a person applying for insurance in excess of the guaranteed issue amounts will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approves such person for such amounts. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete.

I (the employee) permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until the employee's insurance certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha requests additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued.

I will retain a copy of this form with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

SIGNATURE OF EMPLOYEE (REQUIRED AT ALL TIMES) _____ **DATE** __ __/__ __/__ __ __ __

SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE) _____ **DATE** __ __/__ __/__ __ __ __

***SIGNATURE OF CHILD, (IF APPLYING FOR COVERAGE)** _____ **DATE** __ __/__ __/__ __ __ __

***Child signature required only if child is 18 years of age or older.**

Section 8: Form Submission

To help ensure efficient processing for forms **not** submitted online, mail the completed form to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175

FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

EMPLOYEE NAME* _____

Section 5 – Part B Addendum: Health Information for Applicants				
Ques. #	**Name of Applicant**	**Date of Occurrence** (MM/DD/YYYY)	**Date of Recovery** (MM/DD/YYYY)	**Condition, Injury, Diagnosis, Prescription and/or Findings of Exam**