Evidence of Insurability

The University of California - Group Contract Number: 97000

Use this form to enroll in group life insurance outside of your Period of Initial Eligibility (P.I.E.), or to increase life insurance at any time.

Instructions for Employer

1. Complete the information below.
2. Complete all sections of the form noted Part A.
3. The entire package should then be given to your employee for completion of Part B.

Employee Name:_____

Please check the employee's University location:

——— ASUCLA (B4)	——— SAN DIEGO (A6)
——— BERKELEY (A1)	——— SAN DIEGO MC (B6)
——— DAVIS (A3)	——— SAN FRANCISCO (A2)
——— DAVIS MC (B3)	——— SAN FRANCISCO MC (C2)
——— HASTINGS (B2)	——— SANTA BARBARA (A8)
——— IRVINE (A9)	——— SANTA CRUZ (A7)
——— IRVINE MC (B9)	——— UCLA (A4)
——— LBNL (B5)	——— UCLA MC (C0)
——— UCOP (B7)	——— UC MERCED (23)
——— RIVERSIDE (A5)	———

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Part A Employer Information

Complete this page as applicable to the plan(s) requiring evidence of insurability, then give this package to the employee.

Employee First Name | MI | Last Name

Date of Birth | Social Security Number | Sex

☐ Male ☐ Female

Street | Apt.

City | State | ZIP code

Date individual first became eligible for coverage(s)/amount(s) of insurance this form applies to:

Employee Annual Earnings: $_____

Is application being made for amounts above the life non-medical maximum? Yes ☐ No ☐

Is application being made as a late entrant (outside of P.I.E.)? Yes ☐ No ☐

Life Insurance Coverage

(Note: Evidence of Insurability is not required for children.)

To determine the amount of insurance for which the employee is eligible, round the employee's annual salary rate (100% FTE) to the next higher multiple of $1,000 (if it is not an exact multiple of $1,000) and multiply by the selected option (1, 2, 3, or 4 times).

a. If applying for initial amount of employee-paid life insurance, indicate amount: $_____

b. If increasing amount of insurance, indicate:

1) Present amount of employee-paid life insurance: $_____

2) Amount of additional employee-paid life insurance being requested: $_____

c. If applying for employee-paid dependent life insurance, indicate which plan: [

] Basic Dependent Life Insurance ($5,000 - spouse)

[ ] Expanded Dependent Life Insurance

[ ] Spouse Only

d. If applying for initial amount of coverage under Spouse Only under Expanded Dependent Life Insurance, indicate amount of coverage for the spouse:

$_____ Spouse's Coverage Amount
(50% of the employee-paid life insurance amount up to $200,000)

Signed for Employer by:

_____
Name

_____
Title

_____
Telephone Number

_____
E-mail Address

_____
Date

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Instructions for Employee (Complete the required sections as noted below.)

1. If you are providing evidence of insurability for:

a) Employee coverage only–Complete Sections 1, 2, 4, and 5.

b) Dependent coverage only–Complete Sections 1, 3, 4, and 5.

c) Employee and Dependent coverage–Complete all sections of this form.

(Note: Evidence of insurability is not required for children.)

2. Please complete the form in blue or black ink. Sign and date Sections 4 and 5.

3. Please read and tear off the important Medical Information Notice that accompanies these instructions and retain for your records. Please retain a copy of your completed application for your own records.

4. Mail the completed form Part A and Part B to:

The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19176

Or fax the completed form to:
877-605-6671

The evaluation of your request for coverage may be delayed if you do not follow these instructions, if you and/or your dependents do not answer all questions on the Part B form, or if you do not give complete details for any answers requiring details, or if you do not provide complete names and addresses of doctors and hospitals.

NOTE: Coverage is not effective until this request has been approved. You will be notified whether or not coverage has been approved.

If you have questions regarding the completion of these forms, please contact Prudential Customer Service at 888-257-0412 or e-mail us at medical.uw@prudential.com.

Part B Employee Information

Section 1

1. Employee First Name | MI | Last Name

2. Employee Social Security Number ___ – ___ – ____

3. Employee Phone Number
Daytime ___ ___ – ____
Evening ___ ___ – ____

4. Street | Apt.

City | State | ZIP code ____ – ____

5. E-mail Address

Section 2

6. Date of Birth (month day year)

7. Birth Place (city state)

8. Sex ☐ Male ☐ Female

9. Height ___ ft. ___ in.

10. Weight ___ lbs.

Section 2 (continued)

11. Name and address of current doctor:

Physician First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

12. Are you currently able to perform all the duties of your job? ☐ Yes ☐ No
If "No", provide full details in item 17.

13. Have you **during the last five years**:

a. had any surgery or been advised to have surgery and have not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
c. used, or are now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
d. been treated or counseled for alcoholism? Yes ☐ No ☐
e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
f. applied for or received disability income benefits or pension benefits on account of sickness or injury? g. Yes ☐ No ☐
had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? h. Yes ☐ No ☐
been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

14. **Within the last five years**, have you been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

15. Do you **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

16. Have you smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used nicotine gum within the past year? If "Yes", which product? _____ Yes ☐ No ☐

17. What are the full details of all "Yes" answers to each part of 13 through 15? Attach additional pages if needed.

Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began Month Year	Time lost from normal activities	Full recovery (if applicable) Month Year	Print full names, addresses, and telephone numbers of doctors and/or hospitals

Section 3

1. Employee's eligible dependent that requires evidence of insurability.

Full Name	Social Security Number	Relationship to You	Date of Birth	Place of Birth	Height	Weight

2. Address of your dependent (if different from address in Section 1):

3. Is the person named above unable to perform all of the duties of his/her job or home-confined? Yes ☐ No ☐

4. Has the person named above **during the last five years**:

a. had any surgery or been advised to have surgery and has not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
c. used, or are now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
d. been treated or counseled for alcoholism? Yes ☐ No ☐
e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes ☐ No ☐
h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

5. **Within the last five years**, has the person named above been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

6. Does the person named above **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or is he/she currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

7. What are the full details of all "Yes" answers to each part of 3 through 6 above? Attach additional pages if needed.

Dependent's Name	Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began Month Year	Time lost from normal activities	Full recovery (if applicable) Month Year	Print full names, addresses, and telephone numbers of doctors and/or hospitals

Section 4

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, Washington, and the District of Columbia: 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.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia: 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. In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, 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 of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding $5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In 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.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

In Massachusetts: 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 may subject such person to criminal and civil penalties.

In Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

In Washington: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Signature of Employee

Date

Section 5 — AUTHORIZATION For the Release of Information

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility; (2) any insurance company or health maintenance organization (or similar type organization or institution); and (3) the MIB, Inc. formerly known as the Medical Information Bureau. So that eligibility for life or disability coverage can be determined, I authorize you to give any data or records you may have about me or my mental or physical health to The Prudential Insurance Company of America and/or its subsidiaries and, through it, to its reinsurers, authorized agents, and the MIB, Inc. This also applies to any dependent proposed for coverage in the application. This authorization is valid for the lesser of (1) two years after the effective date of any coverage issued in connection with it or (2) 30 months after the date it is signed. A photocopy of this form will be as valid as the original. The person(s) who signed this form (1) have received a copy of the "Medical Information Notice" and (2) may have a copy of this authorization if they wish.

Signature of Employee	Employee Social Security No.	Date

Signature of Spouse (if applicable)	Date

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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, disability, 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 about you in its file. We may reveal this information as necessary, to a doctor, if we find a serious health problem that you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instruction on how to exercise this right. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

It is required that you be given this notice.
Please read it carefully and keep it for your records.

Prudential

Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

  The Prudential Insurance Company of America
  Group Medical Underwriting
  P.O. Box 8796
  Philadelphia, PA 19176

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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, disability, 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 about you in its file. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

Please keep this notice for your records.