

Group Life Insurance Evidence of Insurability

Minnesota Life Insurance Company - A Securian Company
 P.O. Box 14289 • Tallahassee, Florida 32317-4289 • Telephone 888-826-2756 • Fax 850-878-0048

EMPLOYERNAME: State of Florida AGENCY: POLICY NUMBER: 33503

EMPLOYEE INFORMATION (always complete for coverage that requires evidence of insurability)

First name	Middle initial	Last name	Daytime phone number	Evening phone number
Street address		City	State	Zip code
Date of birth	Social Security number	Annual earnings	Date of employment	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Email address				

Total amount of optional insurance requested

No Change
 1x annual earnings
 2x annual earnings
 3x annual earnings
 4x annual earnings
 5x annual earnings
 6x annual earnings
 7x annual earnings

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

First name	Middle initial	Last name	Daytime phone number	Evening phone number
Date of birth	Email address			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Total amount of spouse insurance requested

\$15,000 \$20,000

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

Employee Yes No	Spouse Yes No	Employee		Spouse		Occupation
		Height	Weight	Height	Weight	
<input type="checkbox"/>	<input type="checkbox"/>	1. During the past three years, have you consulted a physician(s), medical doctor, or been hospitalized?				
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever been diagnosed, or been treated by a licensed medical provider for any of the following: heart disorder, lung disorder, kidney disorder, liver disorder, nervous system disorder, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?				
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?				

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, excluding information regarding treatment for HIV/AIDS/ARC)

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

FOR OFFICE USE ONLY:

Employee			Spouse		
Current in force	U/W applied for	Total elected	Current in force	U/W applied for	Total elected
\$	\$	\$	\$	\$	\$

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

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, except for information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, Inc. 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, Inc.

This protected health 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.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand 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 MIB, Inc., a not-for-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, Inc. member company for life or health insurance, or submit a benefits claim for benefits to a member company, MIB, Inc., 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, Inc., 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 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 MIB, Inc. you may contact:

MIB
 50 Braintree Hill, Suite 400
 Braintree, MA 02184-8734
 Telephone: (866) 692-6901
 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. To the best of my knowledge, 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. If coverage is rescinded, an otherwise valid claim will be denied. 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.

Employee name (please print)		Date of birth	
Employee signature	Daytime phone number	Evening phone number	Date signed
X			
Spouse name (please print) (only complete if coverage requires evidence of insurability)		Date of birth	
Spouse signature (only complete if coverage requires evidence of insurability)	Daytime phone number	Evening phone number	Date signed
X			

Please sign and date the Evidence of Insurability form. Please fax all pages to Minnesota Life using this cover page or mail to the address below.

FACSIMILE

To: Minnesota Life Group Underwriting

Fax: 850-878-0048

Phone: 1-888-826-2756

From: _____

Fax: _____

Phone: _____

Date: _____

of pages including this one: ____

Subject: Evidence of Insurability Form

In addition to completing the Evidence of Insurability form, you must also enroll for the coverage with PeopleFirst. You can do so by enrolling online at the PeopleFirst website - PeopleFirst.MyFlorida.com or by phone with the PeopleFirst Service Center at 1-866-663-4735. Once your enrollment is completed with PeopleFirst, the Evidence of Insurability form should be submitted to Minnesota Life.

If you prefer to mail the evidence of insurability form, please send it to the following address:

Mail To: Minnesota Life
PO Box 14289
Tallahassee, FL 32317-4289