



## Frequently Asked Questions About Evidence of Insurability for Applicants

The following questions and answers will help guide you through the process of applying for group coverage with The Standard.

### What Is Evidence of Insurability?

Evidence of Insurability (EOI) is documented proof of good health. An applicant begins the EOI/medical underwriting process by submitting a Medical History Statement (MHS), which along with other information obtained during the underwriting evaluation is used by The Standard to make the underwriting determination.

### When is Evidence of Insurability required?

EOI is generally required for coverage in excess of any applicable guarantee-issue amount, late entrants, reinstatements if required, members and dependents eligible but not insured under the prior plan, and re-applications for previously-declined coverage. Please contact the Office of Personnel/Human Resources Department or see the Evidence of Insurability portion of your group's contract for the requirements specific to your policy.

### Where do I get the Medical History Statements?

You are encouraged to use The Standard's Electronic Evidence of Insurability system (EEOI), which allows you to submit your application electronically, directly and securely to The Standard. Please follow this link to The Standard's Electronic Evidence of Insurability system:  
[www.standard.com/mybenefits/cwbf\\_IA\\_NE/eeoi.html](http://www.standard.com/mybenefits/cwbf_IA_NE/eeoi.html).

The information you are submitting through this site is protected by encryption technology to ensure your confidentiality. We restrict access to information about you to those employees who need to know that information to provide products or services to you. Please read our privacy policy for more details [www.standard.com/forms/corp/9542.pdf](http://www.standard.com/forms/corp/9542.pdf)

Hardcopy medical history statements are also available, if preferred. You may access hardcopy MHS forms through this link: [www.standard.com/eforms/16119\\_648216.pdf](http://www.standard.com/eforms/16119_648216.pdf). Please be sure to select the correct form for your state of residence. Upon completion, print, sign and mail the form to The Standard at the address on the form.

### What information do I need to get started?

Before you begin, please have the following information available:

- Types and amounts of coverage you are requesting
- Physician names and addresses
- Personal identification information (Social Security Number, Date of Birth, etc.)
- Your group name and six-digit policy number:
  - Cooperative Welfare Benefits Fund (Iowa, Nebraska) - 648216

Once you have the required information, you are ready to begin the process.

**If my spouse and/or children are also applying, will they need to submit separate medical history statement(s)?**

Yes, if they are applying for coverage that is subject to EOI (please check with your benefits administrator if unsure). Your spouse should complete and sign his/her own medical history statement.

**What can I expect from Medical Underwriting?**

Once an application is reviewed, we will either approve, decline, or request more information. We may request additional information from you, copies of medical records from your physician, and/or a paramed exam. You will be advised by mail of any request, the process involved, and the date by which the information must be received. Our 800 number will be provided in the letter requesting information in the event you have any questions.

**How long does the underwriting process take?**

The busy annual enrollment season runs from November through March each year. The initial review may take 6-8 weeks during these months. For applications submitted April - October, you can expect a response in 3-4 weeks. Applications requiring additional information will be in addition to these times.

**How will I know the decision?**

You will receive a letter notifying you of the decision. In the event of a declination, you will be told the medical reason(s) for the decision, and be advised of the reconsideration process. The medical reason(s) for the declination will not be shared with anyone but you.

**When is approved coverage effective?**

Generally, coverage becomes effective on the date you are approved for coverage. Premium deductions begin the first of the following month. Refer to your group policy contract or contact the Office of Personnel/Human Resources Department for the specifics of your policy.

**If my application is declined, do you take my existing coverage away?**

No. If some amount of coverage is already in force through a guarantee issue provision or other means, any declination decision will apply only to the portion of coverage that is actually subject to EOI.

**What happens if you don't get the information you need to make a decision?**

In this case, an application will be closed due to Lack of Information (LOI). You will be advised that the application is closed, but we also let you know that if the needed information is received in a reasonable timeframe, your application will be re-opened.

**What do I do if I have a question regarding the status or decision on my application?**

Call the Medical Underwriting Department at 800-843-7979. We are happy to discuss any questions you might have. If your application was declined and if there is any information you could provide that might lead to a favorable decision, we will let you know.

**DIRECTIONS FOR APPLYING FOR COVERAGE**

*Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 3. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.*

**MEMBER/EMPLOYEE INFORMATION**

Name of Group <b>Cooperative Welfare Benefits Fund (Iowa, Nebraska)</b>		Group Number <b>648216</b>	Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name		Birth Date (Mo/Day/Year)	Date Hired (Mo/Day/Year)	
Occupation	Salary	Social Security Number	Member/Employee Identification No.	

**APPLICANT INFORMATION**

Applicant's Name (Person to be insured)		Email Address		
Street Address		City	State/Province	ZIP/Postal Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

**APPLICATION INFORMATION**

**Check the type and provide details on the amount of coverage you are requesting.**

Life

Basic Flex Life (Plan 2)      \_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_  
 Current Amount In Force, if any      Additional Amount Requested      Total Amount Requested

Additional Life (Plan 3)      \_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_  
 Current Amount In Force, if any      Additional Amount Requested      Total Amount Requested

Dependents Life      \_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_  
 Current Amount In Force, if any      Additional Amount Requested      Total Amount Requested

**PHYSICIAN INFORMATION** *(Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)*

Doctor First Name		Doctor Last Name		
Clinic Name			Doctor Phone	
Doctor Address		City	State/Province	ZIP/Postal Code
Date Last Consulted				
Reason Last Consulted				

Applicant Name	Social Security Number
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**MEDICAL HISTORY STATEMENT QUESTIONS**

**Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.**

1. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? .....  Yes  No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
  - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal disorder, or digestive system disorder? .....  Yes  No
  - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? .....  Yes  No
  - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? .....  Yes  No
  - D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? .....  Yes  No
  - E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease? .....  Yes  No
  - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? .....  Yes  No
  - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back or spine, or arthritic conditions? .....  Yes  No
  - H. Endocrine (including thyroid or adrenal), diabetes? .....  Yes  No
  - I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? .....  Yes  No
  - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ...  Yes  No
3. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or HIV antibodies? .....  Yes  No
4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease, disorder, condition or injury? .....  Yes  No
5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, illness, injury, surgery or pregnancy? .....  Yes  No
6. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than cold or allergies not disclosed above? .....  Yes  No

Height \_\_\_\_\_ Weight \_\_\_\_\_

**DETAILS OF ANY "YES" ANSWERS ABOVE**

*Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.*

Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

Applicant Name	Social Security Number
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**ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION** *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any supplemental information, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I authorize The Standard to release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

Signature of Applicant <small>(or Member/Employee for Dependent Child)</small>	Date
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*Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.*

Applicant Name	Social Security Number
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**INFORMATION PRACTICES NOTICE**

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, 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 or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.  
 Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of 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.
- Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

**FRAUD NOTICE**

- ARKANSAS, MAINE, OHIO: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- 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 the 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: 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.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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, NEW MEXICO: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- MARYLAND, RHODE ISLAND: Any person who knowingly or willfully 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 JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- NEW YORK: 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 act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- 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 to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, VIRGINIA, 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.