



EVIDENCE OF INSURABILITY APPLICATION

UT Select Medical Plan and/or Voluntary Group Term Life Insurance (VGTL)

(To be completed by HR staff) Contact Name / Phone Number

PLEASE RETURN THIS APPLICATION TO YOUR CAMPUS BENEFITS OFFICE AFTER COMPLETION. You must complete each page in full, and the application must be signed and dated on Page 3 to be considered. Please complete this application in black or blue ink.

This form cannot be considered unless received by FDL within 30 days of completion. Insurance that requires satisfactory evidence of good health will not be effective for an applicant unless, and until, FDL accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

You are applying for: Health Life Health and Life

- Annual Enrollment Change Change in Status Event (Date of Event) New Hire Retiree Increase

Section A: EMPLOYEE/RETIREE DATA

Check the appropriate UT System component from which you are employed or retired.

- 714 UT - Arlington 721 UT - Austin 747 UT - Brownsville 738 UT - Dallas 724 UT - El Paso 736 UT - Pan American 742 UT - Permian Basin 743 UT - San Antonio 750 UT - Tyler 744 UT - HSC - Houston 745 UT - HSC - San Antonio 785 UT - HC - Tyler 723 UT - M B - Galveston 506 UT - MD Anderson 729 UT - Southwestern 720 UT - System Administration

Form fields for Social Security No., Employee/Retiree Name, Sex, Date of Birth, Height, and Weight.

Form fields for Home Mailing Address - Street, City, State, and Zip.

Form fields for Employee Basic Annual Earnings and Email Address.

Section B: REQUESTED COVERAGE

Form for requested coverage including UT Select Medical Plan and Voluntary Group Term Life Insurance (VGTL).

Section C: SPOUSE DATA to be completed for a spouse applying for the UT Select Medical Plan or VGTL Insurance. DEPENDENT CHILD(REN) DATA to be completed only if applying for the UT Select Medical Plan

Table with columns for Relationship to Employee/Retiree, Name, Social Security No., Date of Birth, Height, and Weight. Rows 1-6 for spouse and dependent children.

NOTE: If additional space is needed, include a separate sheet and please remember to sign and date it.

Employee/Retiree Name _____

Social Security No. _____ - _____ - _____

Section D: HEALTH INFORMATION (Answer all questions fully and truthfully for any person applying for coverage.)

Has any person applying for coverage been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in the questions below? Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "Yes" answers must be provided. Omission of any information may result in an adverse underwriting decision.	Employee/Retiree		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign or malignant)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Alcohol and/or drug addiction and/or substance abuse/treatment, mental, emotional or any other nervous disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Is there a current use of prescribed medications or use in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions 1 through 6?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease or disorder of the nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Any surgical operation performed or advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Is any person applying for coverage currently pregnant? If "Yes", indicate anticipated delivery date _____. Provide details of current/prior complications.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has any person applying for coverage been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions 1 through 11?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explanation of "Yes" answers in Section D – Please provide details of "Yes" answers below. If additional space is needed, include a separate sheet and please remember to sign and date it.

Q #	Person	Condition	Dates From / To	Hospitalized Yes / No	Surgery Yes / No	Treatment / Medication	Current Medication / Remaining Problems	Names and Addresses of Physicians and Hospitals

Employee/Retiree Name _____

Social Security No. _____ - _____ - _____

Section E: AGREEMENTS AND AUTHORIZATION – Please read carefully before signing.

I, the undersigned applicant(s), have read and agree that, to the best of my knowledge and belief, the above statements and answers, and all written, telephonic and electronic information I have provided in support of my Application is complete, true and correctly recorded. I agree that they shall be the basis of the issuance of insurance for me and/or my dependents, if applicable, under the Group Policies. Further, I understand that, except where specifically provided in the Group Policies, Fort Dearborn Life Insurance Company (FDL) and Blue Cross and Blue Shield of Texas (BCBSTX), which are herein collectively called the Company, and/or The University of Texas System shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to the date of approval of my request for insurance. I understand that insurance subject to medical questions requires approval by the Company, and additional medical information, including blood work, may be required to approve such insurance. I also understand that I am responsible to report to the Company's medical underwriting department any change in my health or that of my dependents, if applicable, prior to the date of approval of this Application, and that coverage will not become effective until the Company approves my Application, provided that I am actively at work on that date.

I understand and agree that:

- This authorization is voluntary and that my signature is required in order for the Company to consider this Application and to make a determination on whether to accept and issue the coverage(s) applied for herein;
- If I refuse to sign this authorization, the Company has the right to deny my request for coverage or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire 24 months from the date it is signed;
- All correspondence regarding coverage for those individuals listed on this Application will be sent to the Employee/Retiree.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from the Company.

If my answers on this Application are incorrect or untrue, or if I refuse to sign this authorization, the Company has the right to deny benefits or rescind my coverage or that of my dependents, if applicable, subject to the terms of the contract.

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, HMO, employer, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's underwriting department, its authorized representative(s) or reinsurers, any information relating to me or my dependents concerning medical history, prescriptions, advice, care, or treatment, including any claims processed by BCBSTX, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness or physical condition, HIV (AIDS Virus) or other sexually transmitted diseases.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) 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.

X _____ () _____ () _____
 Signature of Employee/Retiree Date (mm/dd/yyyy) Daytime Phone Evening Phone

X _____ () _____ () _____
 Signature of Spouse (if requesting insurance) Date (mm/dd/yyyy) Daytime Phone Evening Phone

X _____ _____
 Signature of Dependent Child – age 18 and older (if requesting insurance) Date (mm/dd/yyyy)

X _____ _____
 Signature of Dependent Child – age 18 and older (if requesting insurance) Date (mm/dd/yyyy)

X _____ _____
 Signature of Dependent Child – age 18 and older (if requesting insurance) Date (mm/dd/yyyy)

Remember: You must complete this application in its entirety to be considered for coverage. Return this application to your Campus Benefits Office.

**A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association*