UND Life Insurability Kit
Provider: Mutual of Omaha

APPLY WITHIN 31 DAYS OF LIFESTYLE CHANGE, WITHIN 31 DAYS OF EMPLOYMENT FOR COVERAGE OVER THE GUARANTEE ISSUE AMOUNT ON EMPLOYEE/SPOUSE OR DURING THE ANNUAL OPEN ENROLLMENT

1. Complete the UND Life Enrollment form
   - Indicate the total amount of coverage you want to have after medical approval
   - List at least one primary beneficiary
   - Sign the enrollment form

2. Complete the Evidence of Insurability Form
   - Complete sections 2-8
   - Print your name on the top of pages 2-4
   - You must provide the complete name, mailing address and phone number of your physician. Attach a separate sheet if necessary.
   - Employee signature is always required on page 4. Spouse signature is also required if they are applying for coverage. Child signature may be required depending on their age.

3. Return the UND Life Insurability Kit to the UND Payroll Office - Stop 7127 or Twamley Rm 312. Off campus please mail the kit to UND Payroll Office, 264 Centennial Drive Stop 7127, Grand Forks, ND 58202. Completed forms may also be emailed to vicki.robertson@und.edu.

If you have questions regarding this paperwork please call 701-777-2158.

10-17w

UND LIFE Insurance Rates

Term Life Insurance Underwritten by **Mututal of Omaha**

- **Basic Life** - $5,000 life, $5,000 AD&D (employer paid).
- **Employee Supplemental - Up to 10X salary or $500,000 (whichever is less) in $10,000 increments. Minimum of $10,000.** Evidence of insurability is not required for the first $150,000 if application is made within 31 days of hire. Increases after initial hire only excepted within 31 days of a life event change or during open enrollment.
- **Spouse Supplemental - Cannot exceed 50% of employee supplemental.** Evidence of insurability is required for coverage over $20,000 within 31 days of hire. Increases after initial hire only excepted within 31 days of life event change or during open enrollment.
- **Dependent** - $10,000. Covers unmarried children only; live birth through age 25. **Employee supplemental is required.**
- **AD&D** - Personal accident insurance, accidental death, dismemberment, and loss of sight. $500,000 maximum in $10,000 increments.
- **If both husband and wife are UND employees** - Spouse coverage is not an option. Dependent **may not** be insured by more than one member.

Monthly Rates

Employee's Age		Employee and/or Spouse	AD&D Single	AD&D Family	Dependent
		Per $1,000 coverage			$10,000
Under 30		0.022			
30-34		0.030			
35-39		0.066			
40-44	Rates for employee and/or spouse are based on employee's age	0.080	0.020 Rate applies to all ages	0.040 Rate applies to all ages	1.60 Rate applies to all ages
45-49		0.117			
50-54		0.184			
55-59		0.344			
60-64		0.528			
65-69		0.992			
70+ *		1.610			

***Life insurance amounts will be reduced starting at age 70 for active employees. Spouse coverage ends when spouse reaches age 70.**

Upon termination of employment coverage may be converted to a permanent cash value type plan or continue as a term life plan. Coverage ends at age 70. Evidence of insurability will not be required for either if elected within 31 days of termination.

For further information, call the Payroll Office at 701-777-2158.

UND LIFE

Group Term Life and Personal Accident Insurance Enrollment

Life Event Change Form

Life Insurance Coverage Underwritten by:

Mutual of Omaha

Name (Last, First, MI)		Employee ID
Social Security #	Date of Birth	Permanent Employment Date

☐ Increase Coverage ☐ Decrease Coverage ☐ Beneficiary Change

☐ Name Change (Former Name) ____________________

Requested Coverage

☑ Basic Life ($5,000 provided by Employer) $ 5,000

☐ Employee Supplemental Life ($10,000 minimum). ***Maximum 10X salary or $500,000 (whichever is less). Life insurance amounts will be reduced starting at age 70.*** $ ________

☐ Spouse Supplemental Life ($5,000 increments) ***Can't exceed 50% of employee supplemental. Evidence of Insurability is required over $20,000*** $ ________

☐ Dependent Child(ren) (covers all dependent children) ***Must have employee supplemental*** $ 10,000

☐ Personal Accident Coverage ($10,000 increments) ***Maximum $500,000*** $ ________

☐Employee only ☐Family (includes employee)

EMPLOYEE IS AUTOMATICALLY THE BENEFICIARY FOR SPOUSE/DEPENDENT COVERAGE

Designation of Beneficiaries

Primary Beneficiary(ies)	% Share	Relationship	Birth Date	Address
			/ /	
			/ /	
			/ /	

Contingent Beneficiary(ies)	% Share	Relationship	Birth Date	Address
			/ /	
			/ /	
			/ /	

I hereby apply to Mutual of Omaha for Group Term Life Insurance as presented to me and authorize my employer to make any necessary premium deduction from my salary.

Applicant's Signature ____________________ Date Signed ____________

Group Policy # G000AVV8 Effective Date

A Guide for Successfully Completing the Group Insurance Evidence of Insurability Form

United of Omaha Life Insurance Company (United of Omaha) appreciates the opportunity to provide you with valuable insurance protection for yourself and/or your loved ones. So that we can effectively determine if you qualify for group insurance (whether you are seeking new coverage or additional coverage), we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

Please Note: The evidence of insurability form should only be completed if these coverages are provided by your employer through United of Omaha.

Submission Options

- An electronic version can be completed online at *www.mutualofomaha.com/eoi*
- Complete the attached form and mail it to United of Omaha Life Insurance Company.

Important Tips for Paper Copy Submission

- All sections of the form are to be completed by the employee. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting to United of Omaha.

Guidelines for Section 1: Policyholder/Employer Information

The Group ID Number for your employer will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.

Guidelines for Section 2: Employee/Member Contact & Employment Information

Employment information is for your current employer (identified in Section 1) and your current job.

Guidelines for Section 3: Applicant (Proposed Insured) Information

In this section, you only provide information for those applying for coverage, whether yourself (the employee), your eligible dependents, or a combination thereof. (For example, if you are only applying for insurance for yourself and your spouse, you would not provide information for any children.)

Be sure to provide weight in pounds, and height in feet and inches, for all applicants.

Guidelines for Section 4: Requested Insurance

Indicate the type(s) of insurance you are applying for, whether life, short-term disability or long-term disability.

The evidence of insurability form should only be completed if the coverages are provided by your employer through United of Omaha.

Guidelines for Section 5: Requested Life Insurance Benefit Amount

Helpful Hints for (1) Current Amount of Insurance

- If you recently enrolled for life insurance and are applying for coverage in excess of the Guarantee Issue amount, the Guarantee Issue amount is the current amount you should provide.
- If you have had life insurance for some time, and are applying to increase the amount of coverage you have, provide the current amount of coverage you have. Please contact your employer/benefits administrator to confirm current amount(s) if you are uncertain.
- If you (or a dependent) do not currently have coverage, enter 0 (zero).

Helpful Hints for (2) Additional Requested Amount

- This amount is the difference between any current amount you have and the total amount of insurance you would like to have.
- The total amount of insurance available is subject to plan maximums. Consult your employer for additional plan specific information, if needed.

For (3) Total Amount of Insurance Requested, indicate the total amount of life insurance you would like to have.

Guidelines for Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance

- The health information provided in this section is used to underwrite your application for insurance.
- Be sure to answer all questions as honestly and accurately as possible, and provide additional information where indicated.
- For Degree of Recovery, indicate the percent of function you have recovered. (100% indicates full recovery. Any lesser percentage would be a judgment of partial recovery.)
- If you are only applying for coverage for yourself, then answer these questions for yourself only. If you are applying for coverage for any dependents, then answer these questions for anyone included on the form.

Guidelines for Section 8: Authorization to Disclose Personal Information & Application for Insurance

Please read this section in its entirety. By signing, you are applying for insurance coverage with United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of underwriting your application.

For any applicant, if the name associated with any medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.

To be complete, the form must be signed by you, and must also be signed by your spouse if your spouse is applying for coverage.

United of Omaha Life Insurance Company

Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175 Phone: (800) 948-9478

Group Insurance Evidence of Insurability Form

Please print clearly in blue or black ink. All required information should be completed to avoid any delays in the processing of this application. No amount of insurance for which evidence of insurability is required will be effective until approved by the underwriting company. When complete, to help ensure efficient processing and protect your information, mail the completed application to:

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

Section 1: Policyholder/Employer Information (Required fields are marked with an asterisk (*).)

Policyholder/Employer Name*		Group ID Number*
UNIVERSITY OF NORTH DAKOTA		G000 A V V 8
City*	**State***	**ZIP Code**
GRAND FORKS	N D	5 8 2 0 2 - 7 1 2 7

Section 2: Employee/Member Contact & Employment Information (Required fields are marked with an asterisk (*).)

Last Name*	First Name*	MI

Street Address*	Email Address

City*	State*	ZIP Code*	Telephone*
	___	_____-____	(___) ___-____

Full-Time Employment Date (MM/DD/YYYY)*	Annual Salary*	Job Title/Description*	Avg. Hours Worked/Week

Section 3: Applicant (Proposed Insured) Information (Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee/Member is Applying for Insurance

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	SSN/ID Number
	___	☐F ☐M	Lbs.	Ft. In.	___-__-____

Part B – Complete if Applying for Spouse Insurance (for Life Insurance only)

Last Name*	First Name*	MI

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	SSN/ID Number
	___	☐F ☐M	Lbs.	Ft. In.	___-__-____

Note: For all states except AR, KS, and KY, use of the term "spouse" on this application refers to the person to whom you are legally married; or if the policyholder/employer allows or as required by law, your domestic or civil union partner or equivalent, as allowed by federal or state law, or law of the county, city or local government where you live.

Part C – Complete if Applying for Child(ren) Insurance (for Life Insurance only)

Last Name*	First Name*	Gender*	Birth Date (MM/DD/YYYY)*	Weight*	Height*
		☐F ☐M		Lbs.	Ft. In.
		☐F ☐M		Lbs.	Ft. In.
		☐F ☐M		Lbs.	Ft. In.
		☐F ☐M		Lbs.	Ft. In.

Note: If you apply for one child, you must apply for all eligible children. Attach a list of additional children with the above information if necessary.

Section 4: Requested Insurance

Select each insurance product for which you are applying:

☐ Life ☐ ~~Short-Term Disability (STD)~~ ☐ ~~Long-Term Disability (LTD)~~

Section 5: Requested Life Insurance Benefit Amount (Required fields are marked with an asterisk (*).)

	Employee/Member (IF APPLICABLE)	Spouse (IF APPLICABLE)	Child(ren) (IF APPLICABLE)
(1) Current Amount of Insurance (IF ANY)			
(2) Additional Requested Amount			
(3) Total Amount of Insurance Requested* (1+2)			

EMPLOYEE/MEMBER NAME* ______________________________

Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance (A response is required for each question for each applicant.)

Part A

1 – During the past 5 years, has any person proposed for insurance ever been diagnosed by or received medical care from a medical professional for; or for residents of all states except GA, had any disease or disorder associated with; any of the following: (Check all that apply)

Condition	Member	Spouse	Child(ren)	Condition	Member	Spouse	Child(ren)
Urinary tract or kidney?	☐	☐	☐	Lung or respiratory disorder?	☐	☐	☐
Liver or hepatitis?	☐	☐	☐	Chronic fatigue syndrome?	☐	☐	☐
Anemia or blood **(except HIV)**?	☐	☐	☐	Arthritis or joints (incl. replacements)?	☐	☐	☐
Skin or connective tissue?	☐	☐	☐	Epilepsy or any nervous, mental or emotional disorder?	☐ ☐	☐ ☐	☐ ☐
Chronic Epstein-Barr?	☐	☐	☐				
Cancer or tumor?	☐	☐	☐	Breasts or reproductive organs (incl. implants, infertility, irregular cycles, pregnancy complications)?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Alcohol or drug abuse?	☐	☐	☐				
Spine, neck or back?	☐	☐	☐				
Fibromyalgia or myalgia?	☐	☐	☐	Neurological condition (incl. Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
High blood pressure, arteries or veins?	☐	☐	☐				
Stroke or cerebral vascular condition?	☐	☐	☐				
Diabetes or glandular condition?	☐	☐	☐	Any disease of the immune system **(except HIV)**?	☐	☐	☐
Stomach, upper or lower digestive tract?	☐	☐	☐				
Coronary arteries of the heart?	☐	☐	☐				

Question	Member	Spouse	Child(ren)
2 – During the past 5 years, has any person proposed for insurance ever been diagnosed or treated (including medication or recommendation for treatment) by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS); for residents of all states except CO or IN, AIDS Related Complex (ARC); or for residents of all states except CA, IN, ME, NY, VA or VT, Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? **Notice for Residents of CA:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. **Notice for Residents of FL and VT:** The applicant(s) do not have to disclose information relating to AIDS, ARC or HIV unless the diagnosis of those conditions has been made by a licensed physician. **Notice for Residents of ME:** Answer this question "NO" if the person proposed for insurance has tested positive for HIV but has not developed symptoms of the disease AIDS or ARC. **Notice for Residents of MN:** The applicant(s) do not have to disclose an HIV (AIDS Virus) test or test to determine a blood-borne pathogen which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical service personnel at a hospital or medical care facility; or (3) to emergency medical service personnel who were tested as a result of performing emergency medical services.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3 – During the past 5 years, other than for questions 1 and 2 above, has any person proposed for insurance: **(For residents of NJ:** Are any of the following applicable to any person proposed for insurance?) ▪ Been diagnosed or treated by a medical professional? ▪ Had surgery or been hospitalized? ▪ Had a medical or diagnostic examination or evaluation? ▪ Had or been advised to seek treatment for any illness, injury or disorder **(except HIV)**? ▪ Received medical care? **Notice for Residents of ME:** Answer this question "NO" if the person proposed for insurance has tested positive for HIV but has not developed symptoms of the disease AIDS or ARC.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4 – Has any person proposed for insurance been absent from work for more than 5 consecutive working days because of illness or injury during the past five years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5 – Within the past 6 months, has any person proposed for insurance been prescribed medication by a medical professional or taken any medication requiring a prescription?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6 – During the past 5 years, has any person proposed for insurance regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7 – If female, are you pregnant? If Yes, please provide anticipated delivery date (MM/DD/YYYY): ____/____/________	☐ Yes ☐ No	NA	NA

Part B

– For any questions in Part A answered with "Yes", **except for questions about HIV/AIDS/ARC,** the following must be completed, as applicable. Requested dates should be in MM/DD/YYY format. Attach a separate signed and dated sheet containing additional information if necessary.

Ques. #	Name of Applicant	Date of Occurrence	Date of Recovery	Current Status/ Degree of Recovery	Diagnosis/Condition/Treatment/ Medication/Exam Results	Attending Physician's Name, Address & Phone

Part C – If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable. Attach a separate signed and dated sheet containing additional information if necessary.

Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

Section 7: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

Fraud Warning: 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. ***(Note:** This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. If you are a resident of one of these states, please refer to the attached list for the specific fraud warning for your place of residence.)*

Section 8: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 10

- **Medical Persons and Entities** means all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of health care services.
- **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 all health information such as medical history, prescription drug records, mental and physical condition, and drug and alcohol use, and other information such as finances, occupation, general reputation, insurance claims, motor vehicle reports and criminal activity. Personal information does not include psychotherapy notes.
- **Specified Companies** means the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become a part of this group of companies (and their successors), and other persons and/or entities which act on behalf of these companies to provide services to them.

Part B – Authorization to Disclose Information

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and my child(ren) to United of Omaha Life Insurance Company. Personal Information received (a) will be used in connection with the underwriting of insurance; and (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim. **For residents of CA:** This authorization excludes the release of any information relating to any previous tests for HIV Antibodies, T-Cell Counts, AIDS or ARC by any person or entity that may possess such information. **For residents of ME:** This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. **For residents of OK: Such release may include information, which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV) infection, and Acquired Immune Deficiency Syndrome (AIDS). For residents of VT:** This authorization prohibits the release of any information relating to any new tests for HIV Antibodies, T-Cell Counts, AIDS or ARC by United of Omaha Life Insurance Company to any outside, non-affiliated company nor to any entity not under specific contract with the company to perform underwriting services.

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of federal privacy regulations. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. If I am a resident of AZ, disclosure of HIV-related information is only authorized for 180 days from the date the application is signed. I understand I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by United of Omaha Life Insurance Company.

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

____

Part C – Authorization to Receive and Disclose Information to the MIB

I authorize the MIB to disclose Personal Information for me (the undersigned) and my child(ren) to the Specified Companies. 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; and (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize the Specified Companies to disclose Personal Information for me and my child(ren) to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom any person proposed for insurance applies for life or health insurance or to whom any proposed insured may submit a claim for benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by United of Omaha Life Insurance Company.

Section 8: Authorization to Disclose Personal Information & Application for Insurance (Continued)

Part D – Application for Insurance

I apply for insurance for the proposed insured(s) identified in Section 3 of this application who is/are eligible for insurance. Information in this form is given to obtain the insurance requested and is true and complete, and no important circumstance or information has been withheld or omitted, to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I understand that all statements in this application for insurance are deemed representations and not warranties.

I understand that insurance for new or additional amounts of insurance in excess of any guarantee issue amount for any proposed insured does not begin until United of Omaha Life Insurance Company approves such person for such amounts, the proposed insured(s) is/are eligible for the insurance under the terms of the policy, and the appropriate premium is paid. If applicable, I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance for any proposed insured.

I understand that this application is only valid for 90 days from my signature date below. I acknowledge that incomplete information on this application may delay processing. If the Specified Companies request additional medical information to complete processing of this application, I understand that any delay in my response may make it necessary for me to submit a new application. 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 to any proposed insured.

I will retain a copy of this application 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.

Notice for Residents of MA: Caution! If your answers on this application or incorrect or untrue, United of Omaha Life Insurance Company has the right to deny benefits or rescind insurance.

By signing below, I acknowledge that: (a) I understand and agree to the terms of this application; (b) this form has been completed in accordance with the instructions provided; and (c) for residents of all states except CA, I have read the applicable fraud warning for my state of residence.

SIGNATURE OF EMPLOYEE/MEMBER (REQUIRED) ____________________ **DATE** ___/___/______

SIGNATURE OF SPOUSE (IF APPLYING FOR INSURANCE) ____________________ **DATE** ___/___/______

SIGNATURE OF CHILD (IF APPLYING FOR INSURANCE & AGE 18 OR OLDER*) ____________________ **DATE** ___/___/______

*AGE 15 OR OLDER FOR RESIDENTS OF WA

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