

## EVIDENCE OF INSURABILITY INFORMATION

**Instructions for Employee Applicant** (Please complete the required sections as noted below.)

1. If you are providing evidence of insurability for:
  - a. **Applicant (Employee) insurance only — Complete Sections A, C, D, E, F and G.**
  - b. **Dependent (Spouse, Domestic Partner) insurance only — Complete *all* sections of this form.**
  - c. **Applicant (Employee) and Dependent (Spouse, Domestic Partner) insurance — Complete *all* sections of this form.**

*NOTE: Evidence of insurability is not required for children.*

2. Complete the form in ink, and sign and date after **Section G**. Retain a copy of this form for your records.
3. Complete, sign, and date the **AUTHORIZATION** for Applicant and Dependent Applicant.
4. Read the **NOTICE OF INSURANCE INFORMATION PRACTICES** and retain it for your records.

5. Return your completed form to:

**The Lincoln National Life Insurance Company**  
**Group Insurance Service Office**  
**P.O. Box 2616**  
**Omaha, NE 68114**  
**Email: lfgenrollments@LFG.com**

**Or fax the form to:**  
**877-573-6177**

Please take the following steps to avoid delays in our evaluation of your request for insurance:

- Follow all instructions on this sheet.
- Answer all questions (yourself and your dependents) on the form.
- Provide full and complete information for any questions requiring additional details.
- Provide complete names and addresses of any doctors and hospitals.

Any incomplete or incorrect information could result in a delay.

**NOTE:** Insurance is not effective until the company approves in writing. We will notify you of your approval status.

If you have questions on completing this form, please contact Lincoln Financial Group Customer Service at 800-423-2765, or email us at [clientservices@lfg.com](mailto:clientservices@lfg.com).



**The Lincoln National Life Insurance Company**  
 Group Insurance Service Office  
 P.O. Box 2616, Omaha, NE 68103-2616  
 Phone: 800-423-2765 Fax: 877-573-6177  
 Email: lfgenrollments@LFG.com

**EVIDENCE OF INSURABILITY INFORMATION**

Please submit this form to **THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company)**. Insurance that requires evidence of insurability will not be effective until the Company approves in writing.

<b>Employer Completes this Section.</b>	
Group Name: THE CITY OF SAN BRUNO	Group ID/Number/Code: 800003
Billing Division or Location: 1665105	
Policy #(s): 000400001000-26227	

**Complete and return this entire form. Print clearly in ink.** Incomplete forms will delay processing.

**A. Applicant (Employee) Insurance Information**

First Name		Middle Name/MI	Last Name	
Social Security Number		Date of Birth	State of Birth	Employee ID
Street Address (Include Apt. or Suite Number)		City	State	Zip
Cell Phone	Home Phone	Work Phone	Best Time To Call	
Email Address		Gender:	AM/PM	
Average Hours Worked Per Week:		Employee Occupation:		
Earnings:		Date of Employment:		
Is the Employee Actively at Work?		Date of Rehire:		

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate. (Spouse includes your Domestic Partner.)

Type of Group Insurance	Current Amount	Additional Amount	Total Amount
<input type="checkbox"/> Voluntary Life & AD&D (Employee)	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Voluntary Life & AD&D (Spouse)	\$ _____	\$ _____	\$ _____

**B. Applicant (Spouse, Domestic Partner) Information – Only complete if applying for Dependent insurance.**

First Name	Middle Name/MI	Last Name		
_____	_____	_____		
Social Security Number	Date of Birth	State of Birth	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
____-____-____	____/____/____	_____		
<b>Provide contact information if different than the Employee information above.</b>				
Street Address (Include Apt. or Suite Number)		City	State	Zip
_____		_____	_____	_____
Cell Phone	Home Phone	Work Phone	Best Time To Call	
( ) - _____	( ) - _____	( ) - _____	_____ AM/PM	
Email Address				
_____				

## STATEMENT OF HEALTH

### C. Medical Information – Applicants complete if applying for ANY insurance.

Employee:	Height: _____ Ft _____ In.	Weight: _____ lbs.	
Spouse:	Height: _____ Ft _____ In.	Weight: _____ lbs.	

	<b>Employee</b>	<b>Spouse</b>
In the past 12 months, has anyone applying for insurance smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

### D. Medical Information – Applicants complete if applying for Life insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay.

*If you answer YES to ANY part of ANY question below, provide complete details in Section E (Additional Details), including condition, treatment, and names of medication.*

	Employee	Spouse
1. <b>Within the past 7 years</b> , to the best of your knowledge, has anyone applying for insurance had, or been diagnosed or treated by a member of the medical profession for a condition/undergone a procedure listed below:		
a. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement, cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve, atrial fibrillation, abnormal heart rhythm, implantation of pacemaker, or stroke; liver disease, hepatitis, cirrhosis, chronic kidney disease, kidney failure, kidney disease requiring dialysis, kidney stones, polycystic kidney disease, or nephritis; emphysema, chronic obstructive pulmonary disease (COPD), chronic pulmonary disease, cardio-pulmonary disease requiring oxygen, chronic bronchitis, asthma, sarcoidosis, or sleep apnea; mental or nervous disease requiring treatment (including hospital confinement) by a physician, psychiatrist, psychologist, counselor or therapist; alcoholism, drug or substance abuse; internal cancer, lymphoma, melanoma, or leukemia; diabetes, or epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or as a result of a positive ELISA test followed by a positive Western Blot test, tested positive for antibodies to HIV (Human Immunodeficiency Virus) for the purpose of obtaining insurance? <b>CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. a. Has anyone applying for insurance ever been diagnosed by a member of the medical profession with hypertension (high blood pressure)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If 2a is Yes, within the last year, has that person had a systolic (top number) blood pressure reading higher than 150 more than once or a diastolic (bottom number) blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. If 2a is Yes, is anyone applying for insurance taking three or more medications for hypertension (high blood pressure) or had their medications changed or increased within the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. a. Is anyone applying for insurance currently under observation or treatment by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is anyone applying for insurance currently taking any medication(s) prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. <b>Within the past 5 years</b> , to the best of your knowledge, has anyone been diagnosed or treated by a member of the medical profession for a condition/undergone a surgical procedure for:		
a. Thoracic outlet syndrome, backache, or back strain; whiplash, torticollis, ankylosis, vertebrae fracture, spondylosis, spondylolysis, spondylolisthesis, intervertebral rupture, herniation or protrusion of a disc (slipped disc), kyphosis (roundback or Kelso's hunchback), lordosis (curvature of spine), scoliosis; or sciatica?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Osteoarthritis, Rheumatoid Arthritis, or degenerative joint disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Injury to or damage to the ligaments, cartilage, or meniscus of the knee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. <b>Within the past 24 months</b> , to the best of your knowledge, other than colds, flu or normal pregnancy, has anyone applying for insurance lost time from work more than 5 consecutive days due to disability, illness, injury or mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has anyone applying for insurance been told by a member of the medical profession that medical, surgical, psychiatric or rehabilitative care is required in the next 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**E. Additional Details**

**Provide details for any questions answered YES in SECTION D. (Attach additional sheet, if needed.)**

Question Number	Applicant Name	Condition & Length of Condition	Treatment/ Names of Medication	Date of Diagnosis	Current Status of Condition	Attending Physician's Name, Address, and Phone Number

**F. Fraud Warning/State Disclosure(s)**

A PERSON MAY BE COMMITTING INSURANCE FRAUD IF HE OR SHE SUBMITS AN APPLICATION CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH THE INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY. THE FALSITY OF ANY STATEMENT IN THIS APPLICATION SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THE POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE INSURER.

**G. Acknowledgments and Declarations** (Initial each item and sign where indicated.)

1. I request the insurance for which I am (or may become) or my Spouse is (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company; \_\_\_\_\_ (initials)
2. I represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed; \_\_\_\_\_ (initials)
3. I represent that if the above Statement of Health has been completed to obtain insurance for my Spouse, I have discussed and reviewed with my Spouse the responses and information supplied on behalf of my Spouse in the Statement of Health, and to the best of our knowledge and belief, the Spouse portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed; \_\_\_\_\_ (initials)
4. I acknowledge that I have read the **Fraud Warning/State Disclosure(s)**; \_\_\_\_\_ (initials)
5. I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue insurance as outlined in the contract; and \_\_\_\_\_ (initials)
6. **The attached AUTHORIZATION has been completed and signed by me (Employee Applicant). A separate authorization has been completed and signed by the (Spouse) Applicant.** \_\_\_\_\_ (initials)

Signature of (Employee) Applicant: **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of (Spouse) Applicant: **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PAYROLL DEDUCTION AUTHORIZATION (Sign where indicated):**

I authorize any required deductions from my earnings.

Signature of (Employee) Applicant: **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE COMPLETE THE ATTACHED AUTHORIZATION  
(EACH APPLICANT MUST COMPLETE AND SIGN HIS/HER OWN AUTHORIZATION)  
Return all pages to avoid processing delays.**



## NOTICE OF INSURANCE INFORMATION PRACTICES

### COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance on a fair and equitable basis, we must collect information about you and others for whom insurance may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

### DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

MIB, Inc.

Information regarding your insurability will be treated as confidential. The Lincoln National Life Insurance Company or its reinsurers 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 or health insurance, 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.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901. If you question the accuracy of the information in the MIB's file, you may contact the 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](http://www.mib.com).

### PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

### TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:

The Lincoln National Life Insurance Company  
Group Insurance Service Office  
P. O. Box 2616  
Omaha, Nebraska 68103-2616

**DETACH THIS COPY AND KEEP FOR YOUR RECORDS**



# Providing evidence of insurability

If you're required to provide evidence of insurability to Lincoln Financial Group as part of an insurance application, you can do it online through a quick and confidential process. Here's some helpful information on what evidence of insurability means and how to determine whether it's required of you.

## What you need to know

### What is evidence of insurability (EOI) and when is it needed?

Evidence of insurability is the information we use to verify good health when you buy life, disability or critical illness insurance for these reasons:

- You are buying an insurance amount higher than the guaranteed amount for your plan.
- You are already enrolled and want to increase coverage.
- You declined coverage when first eligible but now want coverage.
- You are applying for coverage more than 31 days after your plan's eligibility period.

Lincoln reserves the right to require evidence of insurability for other reasons not specified here.

### What is Guarantee Issue?

This is the amount of insurance coverage available to you regardless of health status — amounts up to the Guarantee Issue do not require evidence of insurability.

### How do I submit evidence of insurability?

Complete and return the Evidence of Insurability paper form mailed to you that includes your EOI request details, or you can fill out the Evidence of Insurability form online through our secure website. Go to [LincolnFinancial.com/EOI](http://LincolnFinancial.com/EOI) and follow the three easy steps:

- |               |                      |
|---------------|----------------------|
| <b>Step 1</b> | Coverage             |
| <b>Step 2</b> | Personal information |
| <b>Step 3</b> | Health questions     |

Make sure you:

- ✓ Review your answers
- ✓ Print a copy of the EOI form for your records
- ✓ Electronically sign your form when you submit it

### What information do I need to submit evidence of insurability?

When it's time to submit your application, you can help speed things along by gathering some key information to start.

Here is a checklist of information you'll need:

- Group ID and/or policy number,\* or your employer's name
- Any existing coverage and its current amount
- Type and amount of coverage you are requesting to elect or increase
- Names and addresses of your physician(s) and any hospital(s) where you've recently been treated

\*You can obtain the group ID and/or policy number (the preferred way to identify your plan) by calling your plan administrator, who will also have information on the types and amounts of coverage.

### What happens after I submit evidence of insurability?

The evidence of insurability will be reviewed, and we will notify you and your employer when we reach a decision.

During our review process, a trained medical professional from **APPS Para Medical Services** may call you to complete a brief medical report. APPS may need to schedule an appointment with you to complete services, such as vital measurements or a blood draw. **APPS Para Medical Services** can be reached at 800-727-2101.



### Submit online or complete a paper form

Going online to [LincolnFinancial.com/EOI](http://LincolnFinancial.com/EOI) to submit evidence of insurability is quick and easy. But if you prefer completing a paper form, fill out the one mailed to you or print the form from our website.



### Need help?

Go to [LincolnFinancial.com/EOI](http://LincolnFinancial.com/EOI) or contact us at 800-423-2765 or [ClientServices@LincolnFinancial.com](mailto:ClientServices@LincolnFinancial.com).

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[LincolnFinancial.com](http://LincolnFinancial.com)

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LCN-2638994-071119

MAP 1/20 **Z08**

**Order code: GP-EOIEE-FLI001**



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APPS Para Medical Services is the largest provider of paramedical services for the purpose of gathering information to be used in the underwriting of life, disability, and group insurance. APPS Para Medical Services is not a Lincoln Financial Group® company. Each independent company is solely responsible for its own obligations.