2019 Annual Enrollment

PORTICO BENEFIT SERVICES EVIDENCE OF INSURABILITY (EOI) INSTRUCTIONS

Please complete and submit the attached form within two weeks of receiving it.

Negotiated group rates on basic, supplemental, and dependent life insurance are offered by Securian Financial and underwritten by Securian Life Insurance Company (Securian). Your requested life insurance will not be effective until Securian notifies Portico Benefit Services that your request has been approved.

If your request is to:

A. Start or increase supplemental life insurance for yourself:

1. **Complete the Employee Information section.** Your Employee ID is your Portico Member ID number, which is found on myPortico in the upper right corner after you sign in (see drop-down arrow). You do not need to complete the Spouse/Domestic Partner Information and Child Information sections if you are not starting or increasing supplemental life insurance for a spouse, eligible same gender partner (ESGP), or child.
    - **Do NOT complete the “Total Amount of Insurance Requested.”** Your request was collected through myPortico, and it will be transmitted to Securian. Leave this section blank.
2. **Answer the three employee health questions.**
3. **Enter your height and weight.**
4. **Provide Additional Health Information as required; attach a separate sheet of paper if necessary.**
5. **Print, sign, and date the form.**

B. Start or increase life insurance for your spouse or ESGP:

1. **Complete the Employee Information section.** Your Employee ID is your Portico Member ID number, which is found on myPortico in the upper right corner after you sign in.
2. **Complete the Spouse/Domestic Partner Information section.**
    - **Do NOT complete the “Total Amount of Insurance Requested.”** Your request was collected through myPortico, and it will be transmitted to Securian. Leave this section blank.
3. **Answer the three Spouse/Domestic Partner health questions.**
4. **Enter your spouse’s/ESGP’s height, weight, and occupation.**
5. **Provide Additional Health Information as required; attach a separate sheet of paper if necessary.**
6. **Print, sign, and date the form.**
7. **Have your spouse or ESGP sign and date the form.**

C. Start or increase life insurance for your dependent children:

1. Evidence of Insurability is not required to purchase or increase supplemental life for your dependent children.
2. Even if you are submitting this form to provide Evidence of Insurability for yourself and/or your spouse or ESGP, do not include information about your children on this form.

Fax or mail the completed and signed form directly to Securian (fax: 651.665.7092; address below).

PORTICO®
Benefit Services | A Ministry of the ELCA

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

FACSIMILE

To: **Securian Life - Group Underwriting**

Fax: 651-665-7092 Phone: 1-800-872-2214

From: ____

Fax: _________________ Phone: __________________

Date: ______________________ # of pages including this one: ___

Subject: **Evidence of Insurability Form**

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

Mail To: Securian Life Insurance Company
Group Division Underwriting
PO Box 64136
St Paul, MN 55164-0136

Group Life Insurance Evidence of Insurability

Securian Life Insurance Company
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098 • Fax 651-665-7092

EMPLOYER NAME: Portico Benefit Services **POLICY NUMBER: 70049**

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	Employee ID	Annual salary	Date of employment	Gender ☐ Male ☐ Female

Total amount of insurance requested

☐ No change ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000

Email address

SPOUSE/DOMESTIC PARTNER INFORMATION (only complete if coverage requires evidence of insurability)

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Date of birth	Email address	Gender ☐ Male ☐ Female

Total amount of insurance requested

☐ No change ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 (not to exceed 50% of the member's supplemental life)

CHILDREN INFORMATION (only complete if coverage requires evidence of insurability and list names and dates of birth)

Total amount of insurance requested

☐ No change ☐ $5,000 ☐ $10,000

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

In answering the following questions, you need not disclose an HIV (AIDS Virus) test 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 services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

Employee Height	Employee Weight	Spouse/domestic partner Height	Spouse/domestic partner Weight	Occupation

Employee Yes	Employee No	Spouse/DP Yes	Spouse/DP No	Children Yes	Children No	Question
☐	☐	☐	☐	☐	☐	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s) or been hospitalized?
☐	☐	☐	☐	☐	☐	2. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
☐	☐	☐	☐	☐	☐	3. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as Acquired Immune Deficiency Syndrome (AIDS), or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

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)

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

FOR OFFICE USE ONLY:

Employee			Spouse/Domestic Partner			Children		
Current in force	U/W applied for	Total elected	Current in force	U/W applied for	Total elected	Current in force	U/W applied for	Total elected
$	$	$	$	$	$	$	$	$

PLEASE READ & SIGN BELOW & SEND ALL PAGES TO SECURIAN 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 Securian Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also 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.

If I do not revoke this authorization, it will be valid for as long as I am continually insured with Securian Life Insurance Company. 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
Securian 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, Inc.
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
Telephone: (866) 692-6901
Website: www.mib.com

This authorization excludes the release of information about HIV (AIDS Virus) tests to which were 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 services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. 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. The answers given are true and complete. It is understood that Securian 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.

Employee signature X	Employee name (please print)	Date of birth	Phone number	Date signed
Spouse/domestic partner signature X	Spouse/domestic partner name (please print)	Date of birth	Phone number	Date signed
Children (age 18 and older) signature X	Children name (please print)	Date of birth	Phone number	Date signed