S.C. Public Employee Benefit Authority
Evidence of Insurability Process

For Employees and/or their Spouse

The information below and the attached Evidence of Insurability form are being provided to you in response to your recent request to increase your life insurance coverage. Your election requires you to complete the Minnesota Life Evidence of Insurability Form.

Please answer applicable questions completely and accurately, and include your daytime phone number so that you may be contacted if additional information is needed.

S.C. Public Employee Benefit Authority – Benefits Administrator

Please complete the following in advance of providing the Evidence of Insurability form to the employee:

- Complete the "For Benefits Administrator Use Only" section on the bottom of page 1 of the Evidence of Insurability form. Include the optional and/or spouse life amount subject to medical underwriting and the total optional and/or spouse life amount elected.
- Include the Employee's Reporting Location (Employer Group #)
- Give the form and instructions to the employee.

If you have any questions about the form, you may contact Minnesota Life – Medical Underwriting at **800-872-2214** between 7 a.m. and 7 p.m., CT.

S.C. Public Employee Benefit Authority (PEBA) – Employee

Please complete the Minnesota Life Evidence of Insurability Form, and sign and date it where indicated. Don't forget to include your Benefits Identification Number (BIN).

- Note that if you leave questions unanswered, the underwriting process may be delayed.
- If you answer "Yes" to any of the health questions, please provide complete details (including the name, mailing address, and phone number of the doctor or facility that has your medical records).

Send the form directly to Minnesota Life, either by fax to **651-665-7092**, or via mail as follows:

Minnesota Life
Group Division Underwriting
P.O. Box 64136
St. Paul, MN 55164-0136

If you mail the form, be sure to keep a copy for your records.

Please note: To evaluate your application, additional information may be needed from you or your doctor. Some coverage and amounts may require a brief health evaluation including a paramedical exam, a blood test, urinalysis and/or EKG. The paramedical exam and any necessary tests will be performed at a time and place of your choice and there is no cost to you. If an exam is required, you will be notified by Minnesota Life and contacted by their national paramedical provider.

Minnesota Life will keep you informed throughout the underwriting process. If you have any questions about the status of your application, please do not hesitate to contact Minnesota Life Medical Underwriting Customer Service at **800-872-2214** between 7 a.m. and 7 p.m., CT.

After your application has been reviewed, Minnesota Life will mail you a Notification Statement documenting their decision on your coverage increase request. If approved, S.C. Public Employee Benefit Authority (PEBA) will enter the appropriate payroll deductions for the new coverage. If denied, Minnesota Life will correspond directly to you to provide you with specific details.

Group Life Insurance Evidence of Insurability

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

MINNESOTA LIFE

POLICYHOLDER: S.C. Public Employee Benefit Authority **POLICY NUMBER: 34407**

Employer Group Name: _____ **Employer Group #** _____

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	Benefits Identification Number (BIN)	Annual salary	Date of employment	Gender
				☐ Male ☐ Female

Email address

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

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

Date of birth	Gender
	☐ Male ☐ Female

Email address

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

Employee		Spouse		Employee		Spouse		
Yes	No	Yes	No	Height	Weight	Height	Weight	Occupation
☐	☐	☐	☐					
☐	☐	☐	☐					
☐	☐	☐	☐					

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 had, or been treated for, any of the following: 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 as having 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 BENEFITS ADMINISTRATOR USE ONLY:

Employer Group Name: _____
Reporting Location (Employer Group #) _____

Employee

Optional Life subject to medical underwriting	Total Optional Life elected
$	$

Spouse

Spouse Life subject to medical underwriting	Total Spouse Life elected
$	$

PLEASE READ & SIGN NEXT PAGE & SEND ALL PAGES TO MINNESOTA 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 Minnesota 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 Medical Information Bureau (MIB) 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, 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.

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.

This Authorization shall remain in force for 24 months following the date of my signature below. 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 the Medical Information Bureau (MIB), a non-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 member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, 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 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
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
MIB Telephone: (866) 692-6901
MIB TTY: (866) 346-3642
Website: www.mib.com

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 Minnesota 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 name (please print)		Date of birth	
Employee signature X	Daytime phone number	Evening phone number	Date signed
Spouse name (please print)		Date of birth	
Spouse signature X	Daytime phone number	Evening phone number	Date signed

Before sending, please make sure that all of the required information is included as indicated, for each individual that requires underwriting.

Please note: If any required information is incomplete or missing, the underwriting process may be delayed

- ☐ Include an authorization signature and date on the Evidence of Insurability form for each individual that requires underwriting

- ☐ Submit all pages (front and back if not blank)
  - By fax using this cover page to the fax number below
  - Or by mail to the address below

FACSIMILE

To: **Group Life Medical Underwriting**

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

From: _____

Fax: _____ Phone: _____

Date: _____ # of pages including this one: ___

Subject: **Evidence of Insurability Form**

Message:

Mail To: **Minnesota Life ▪ Securian Life**
Group Division Underwriting
PO Box 64136
St Paul, MN 55164-0136