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

**Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. So that we can effectively determine if you qualify for group disability 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.**

### Submission Options

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

### 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 Mutual of Omaha.

### Guidelines for Section 1: 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 Contact & Employment Information

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

To ensure any additional correspondence regarding your form occurs as quickly as possible, check the box to consent to receive future correspondence via email.

### Guidelines for Section 3: Employee Personal Information

All fields in this section are required.

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

### Guidelines for Section 4: Requested Coverage

Indicate the type of insurance you are applying for, whether short-term disability, long-term disability or both.

### Guidelines for Section 5: Health Information

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.)

### Guidelines for Section 7: Authorization to Disclose Personal Information & Application for Insurance

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

If the name associated with any of your 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.

## NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, Mutual of Omaha and its affiliated companies ("we") will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO – ATTN: GROUP UNDERWRITING INDIVIDUAL SELECTION; MUTUAL OF OMAHA; MUTUAL OF OMAHA PLAZA; OMAHA, NE 68175.**

## MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Mutual of Omaha and its affiliated companies, or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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, Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Mutual of Omaha and its affiliated companies, or its reinsurers, may also release information in its 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.

## FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

Mutual of Omaha and its affiliated companies, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address – Attn: Group Underwriting Individual Selection; Mutual of Omaha; Mutual of Omaha Plaza; Omaha, NE 68175.

## INVESTIGATIVE CONSUMER REPORTS NOTICE

Mutual of Omaha and its affiliated companies ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation.

You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it.

We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

# Group Disability Insurance
# Evidence of Insurability Form

Underwritten by: United of Omaha Life Insurance Company Home Office: Omaha, Nebraska

**Section 1: Employer Information** (Please print clearly. Required fields are marked with an asterisk (*).)

| **Employer's Name*** | **Group ID Number*** |
|---|---|
| DOMINICAN UNIVERSITY OF CALIFORNIA | G000 C 4 D B |

| **Street Address** | **Telephone** (xxx)xxx-xxxx |
|---|---|
| | |

| **City*** | **State*** | **ZIP Code** |
|---|---|---|
| | __ __ | |

**Section 2: Employee Contact & Employment Information** (Please print clearly. Required fields are marked with an asterisk (*).)

| **Last Name*** | **First Name*** | **Middle Name** |
|---|---|---|
| | | |

| **Street Address*** | **Email Address** |
|---|---|
| | |

| **City*** | **State*** | **ZIP Code*** | **Telephone*** (xxx)xxx-xxxx |
|---|---|---|---|
| | __ __ | | |

| **Full-Time Employment Date** (MM/DD/YYYY)* | **Job Title/Description*** |
|---|---|
| | |

**Consent to Email Correspondence**

☐ Check this box if you consent to receiving future correspondence regarding this form via email.

**Section 3: Employee Personal Information** (Please print clearly. Required fields are marked with an asterisk (*).)

| **Birth Date** (MM/DD/YYYY)* | **State of Birth*** | **Gender*** | **Weight*** | **Height*** | **Annual Salary*** |
|---|---|---|---|---|---|
| | __ __ | ☐ Female ☐ Male | _____ Pounds | ____ Ft. ____ In. | $ |

**Section 4: Requested Coverage**

**Indicate the type of coverage you are applying for:**

☐ **Short-Term Disability (STD)** ☐ **Long-Term Disability (LTD)** ☐ **Both STD and LTD**

**Section 5: Health Information** (Please print clearly. A response is required for each health question.)

**Part A – Health Questions**

**Health Question 1**

During the past five years, have you received medical care from a medical professional for, or had any disease or disorder associated with, any of the following:* (Check all that apply.)

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

☐ **None of the Above**

| **Health Question 2** | **Response*** |
|---|---|
| During the past seven years, have you been diagnosed or treated by a member of the medical profession for having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | ☐ YES ☐ NO |
| **Health Question 3** | **Response*** |
| During the past seven years, other than questions 1 and 2 above, have you had surgery or been hospitalized? | ☐ YES ☐ NO |

**Section 5 Cont'd: Health Information** (Please print clearly. A response is required for each health question.)

| **Health Question 4** | **Response*** |
|---|---|
| Have you been absent from work for more than five consecutive working days because of illness or injury during the past five years? | ☐ YES<br>☐ NO |
| **Health Question 5** | **Response*** |
| Within the past six months, have you been prescribed medication by a medical professional or taken any medication requiring a prescription? | ☐ YES<br>☐ NO |
| **Health Question 6** | **Response*** |
| During the past seven years, have you regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics)? | ☐ YES<br>☐ NO |
| **Health Question 7** | **Response*** |
| If female, are you pregnant?<br>If YES, please provide anticipated delivery date (MM/DD/YYYY): | ☐ YES<br>☐ NO |

**Part B – If you responded YES to questions 1, 2, 3, 4 or 6 above, you must complete the following, as applicable:**

| **Ques. #** | **Condition, Injury, Diagnosis, Symptom of Ill Health, Type of Operation and/or Findings of Exam** | **Date of Occurrence** (MM/DD/YYYY) | **Duration** (WEEKS, MONTHS OR YEARS) | **Degree of Recovery** |
|---|---|---|---|---|
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**Part C – If you responded YES to question 5 above, you must complete the following, as applicable:**

| **Medication Name** (FROM PRESCRIPTION LABEL) | **Dosage/Frequency** | **Dates Taken** (MM/DD/YYYY - MM/DD/YYYY) | **Reason for Taking** |
|---|---|---|---|
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**Section 6: Required Fraud Warnings – Please Read**

For your protection, California law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## Section 7: Authorization to Disclose Personal Information & Application for Insurance

### Part A – Definitions of Terms Used in Section 7

**MIB, Inc.** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.

**Personal Information** means information about me, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

### Part B – Authorization to Receive and Disclose Personal Information

**To MIB, Inc.:** I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company ("Mutual of Omaha") or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information about me to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to MIB, Inc. I understand that the Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it.

**Name(s) used for medical records (if different than the name provided on the form):** _____

_____

### Part C – Application for Insurance

I apply for disability insurance for me. I understand that any insurance in excess of the guaranteed issue amount will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approve the amount. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until my certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha request additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

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.

I will retain a copy of this form 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.

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

**SIGNATURE OF EMPLOYEE** _____ **DATE** __ __/__ __/__ __ __ __

## Section 8: Form Submission

To help ensure efficient processing, mail the completed form to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
3300 Mutual of Omaha Plaza
Omaha, NE 68175

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

**EMPLOYEE NAME*** _____

## Section 5 Addendum: Health Information

### Part B – Addendum:

| Ques. # | Condition, Injury, Diagnosis, Symptom of Ill Health, Type of Operation and/or Findings of Exam | Date of Occurrence (MM/DD/YYYY) | Duration (WEEKS, MONTHS OR YEARS) | Degree of Recovery |
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### Part C – Addendum:

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