EMPLOYEES RETIREMENT SYSTEM OF TEXAS
Texas Employees Group Benefits Program (GBP)
Disability Evidence of Insurability (EOI) Application

Evidence of Insurability (EOI) may be required to enroll in GBP disability income insurance coverages.

Evidence of Insurability means that you must provide, at no expense to Dearborn National® Life Insurance Company (Dearborn National), evidence of good health. To be considered for coverage, the EOI Application (Form No. R0801_12 I Z4306_ERS) must be completed in its entirety, signed, dated, and returned to Dearborn National. You are required to answer the medical questions which may include providing medical records and a physical exam. The information you provide on the EOI Application and any additional information requested and received is subject to review and approval by Dearborn National Medical Underwriting. **Coverage will either be approved or denied based on the information provided.**

GENERAL INSTRUCTIONS

Important: Write your agency name, agency number and region number in the box in the upper right-hand corner of the Application. If you need assistance in completing this section contact your benefits coordinator or refer to the agency list found with the EOI form at www.ers.state.tx.us/customer_support/forms. (Click on "Use the agency list in alpha order or in numerical order" under the Form Description column.)

SECTION A: EMPLOYEE DATA
Complete this section and specify your complete mailing address and ZIP Code. ***Important:*** To prevent processing delays, provide the last four digits of your Social Security Number, ERS OnLine employee identification number and current height/weight.

SECTION B: EMPLOYEE COVERAGE ADDITIONS
Only check the box(es) for new coverage(s) you are applying for. DO NOT check the box(es) for coverage(s) you already have.

SECTION C: HEALTH INFORMATION
Important: You must answer all questions to apply for coverage. If you answer "Yes" to any question, please use the space in Section D on page 3 to provide details. Failure to provide details will cause a delay in the review of your Application.

SECTION D: AGREEMENTS AND AUTHORIZATION
Please read the Agreements and Authorization before signing the Application. Your signature is required and must be legible. The Application must be dated with the current month, day and year.

Provide work and home phone numbers and include extension numbers, if applicable. You should keep a copy of the completed Application for your own records.

Return the completed Application (pages 1-3) to:

Dearborn National
Administrative Offices, Attn: Medical Underwriting Dept.
P.O. Box 655403
Dallas, Texas 75265-5403

For underwriting questions or the status of an EOI application please call:
(855) 377-5433 Monday – Friday 8:00 a.m. – 4:30 p.m.

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

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REMEMBER: You must complete this application in its entirety to be considered for coverage.
Return this application to:

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To be completed by the Employee		
Agency Name:	Agency No.	District / Region No.
❑ Annual Enrollment		
❑ Qualified Life Event	Date of Event ___/___/___	
❑ New Hire	Date of Hire ___/___/___	

You must complete each page in full, and the application must be signed and dated on Page 3 to be considered. Please complete this application in black or blue ink. This form will not be considered unless received by Dearborn National® Life Insurance Company (Dearborn National) within 30 days of completion. Insurance that requires satisfactory evidence of good health will not be effective for an applicant unless, and until, Dearborn National accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

Section A: Employee Data (This section must be filled out completely for application to be considered.)

Last 4 digits of SSN X X X - X X -	Name: Last First MI	Date of Birth Mo. Day Year	Height Ft. / In.	Weight Lbs.
ERS Online Employee ID:		/ /		

Home Mailing Address - Street	City	State	Zip
Sex ❑ Male ❑ Female	Employee Hire Date _____/_____/_____		

Section B: Employee Coverage Additions (Please do not reapply for existing coverage.)

Optional Coverages
(Administered by Dearborn National® Life Insurance Company)

Disability Income Insurance (Employees only)	❑ Short-term Disability ❑ Long-term Disability

Section C: Health Information (Answer all questions, fully, accurately, and truthfully.)

Check either **"Yes"** or **"No"** to each question and **circle the specific conditions(s)**. **Details to all "Yes" answers must be provided in Section C on page 2. Failure to provide full information or providing false information may result in denial of benefits and/or possible sanctions.**	**Employee**
1. Have you been seen, treated, advised or received services from any health provider in the last 12 months, including routine physicals?	❑Yes ❑No
2. Have you ***EVER HAD*** **symptoms, been diagnosed with, and/or received treatment by/from a member of the health profession for any of the conditions listed in the questions below?**	
a. High blood pressure, heart attack, chest pain, shortness of breath, irregular heartbeat, murmur, coronary artery disease, heart surgery (catheterization/angioplasty/bypass, etc.), or any other disease or disorder of the heart or circulatory system?	❑Yes ❑No
b. Enlarged glands, thyroid disorder, diabetes, abnormal glucose level, hepatitis, cirrhosis, abnormal liver studies, hernia, ulcer, colitis or any other disease or disorder of the liver, endocrine, or digestive system?	❑Yes ❑No
c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia or any other mental/nervous/behavioral disorder?	❑Yes ❑No
d. Asthma, emphysema, tuberculosis, pneumonia, COPD, sleep apnea, or any other disease or disorder of the throat, lungs, or respiratory tract?	❑Yes ❑No
e. Prostate, uterus/tubes/ovaries, endometriosis, cystitis, kidney stone, renal failure, sexually transmitted diseases, any disorder of the kidneys/bladder/urinary tract, breast lumps/changes/ biopsies, abnormal test results or any other male/female disorder?	❑Yes ❑No
f. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign/malignant)?	❑Yes ❑No
g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, or any other disease or disorder of the nervous system?	❑Yes ❑No
h. Arthritis, gout, rheumatism, neck or back strain/sprain/injury, deformity, loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	❑Yes ❑No

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

Dearborn National®

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Employee Name_____ **Last 4 digits of SSN** X X X - X X - _____

Section C: (Cont'd) Health Information (Answer all questions, fully, accurately, and truthfully.)	
Check either **"Yes"** or **"No"** to each question and **circle the specific conditions(s)**. **Details to all "Yes" answers must be provided below. Failure to provide full information or providing false information may result in denial of benefits and/or possible sanctions.**	**Employee**
3. Have you been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	❑Yes ❑No
4. Do you currently take medication (prescription or otherwise), been prescribed medication, or have you done so in the last 6 months?	❑Yes ❑No
5. Within the last 2 years, have you had a physical disability, surgery, or been confined to a hospital, skilled nursing or rehabilitation facility, undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, MRI, CAT Scans, PET or CT Scans, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment; and/or been advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed, not mentioned in questions 1 through 4?	❑Yes ❑No
6. Are you currently pregnant? If **"Yes"**, indicate anticipated delivery date _____. **Provide details of any current/prior complications below.**	❑Yes ❑No
7. Have you *EVER HAD* symptoms, been diagnosed with, and/or received treatment from a member of the health profession for **ANY HEALTH CONDITION** other than those conditions listed above?	❑Yes ❑No

Explanation of "Yes" answers in Section C – Please provide details of "Yes" answers below. If additional space is needed, include a separate sheet and please remember to sign and date it.

Question No.	Condition	Dates From / To	Hospitalized Yes / No	Surgery Yes / No	Treatment / Medication	Current Medication / Remaining Problems	Names /Addresses of Practitioners / Hospitals

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Employee Name_____ **Last 4 digits of SSN** XXX-XX-_____

It is the responsibility of the applicant/patient to obtain the requested medical information. The Attending Physician's Statement (APS) form includes a Patient's Authorization to release medical information. The patient must sign and date the authorization form(s) and send to the doctor/facility listed on the form(s). Any fee charged for completion of the APS form(s) and release of medical records is the responsibility of the applicant/patient.

Section D: AGREEMENTS AND AUTHORIZATION – Please read carefully before signing.

I, the undersigned applicant, have read and agree that the above statements and answers are furnished in support of my Application and are complete, true and correctly recorded to the best of my knowledge and belief. I agree that they shall be relied upon as the basis of the issuance of insurance for me. Except where specifically provided in the applicable group policies, under which coverage is provided, Dearborn National® Life Insurance Company (Dearborn National) and/or Employees Retirement System of Texas (ERS) shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to approval of my request for insurance.

I also understand that incorrect, incomplete, or untrue or misleading answers on this Application may result in rescission of my coverage or denial of any claims subject to the terms of the contract, and may be cause for permanent expulsion from the Texas Employees Group Benefits Program ("GBP") or other sanctions according to the terms of Chapter 1551, Texas Insurance Code.

I understand and agree that:

This authorization is voluntary but that my signature is required in order for Dearborn National to consider this Application for me and to make a determination on whether to accept and issue the coverage(s) applied for herein;

- If I refuse to sign this authorization, Dearborn National has the right to deny my request for coverage, if applicable;
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the Federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire the later of 24 months from the date it is signed or at the end of any appeal process concerning this Application;
- All correspondence regarding coverage for this Application will be sent to the Employee;
- The information I have provided in this Application is true, correct, and complete to the best of my knowledge.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from Dearborn National.

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, HMO, MCO, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn National's underwriting department or its authorized representative(s) and ERS any information relating to me concerning advice, care, or treatment, including any claims processed by a third party Administrator or carrier currently or formerly under contract with ERS, and prescriptions for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance coverage or statement of claim containing any materially false information, or conceals or omits 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. A person who commits a fraudulent insurance act or who induces the extension of coverage or payment of a claim by a materially negligent or intentional misrepresentation of fact may be subject to sanctions or expulsion from the GBP.

X_____	_____	(____)_____	(____)_____
Signature of Employee	**Date**	**Daytime Phone**	**Evening Phone**

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