

Portable Proof of Good Health Form

If both employee and spouse are applying, they must submit **SEPARATE** forms.

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Applicant: If you are concerned about confidentiality, you may send this form directly to the insurance company: ReliaStar Life Insurance Company, Box 20, Mail Stop 2-N, Minneapolis, MN 55440 or FAX: 612-342-7626.

Name of Employer/Plan Sponsor City of Eugene	Group/Plan Number 36155-1	Account Number/Location	Employee's Date of Hire
Name and phone number of the Benefits person in the Human Resources Department: Name: Tina Dixon Phone (541) 682-8868		Employee's Name (print):	
This form needed due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Late Entrant (<i>enrolling after the 1st available opportunity</i>) <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Add Dependent Coverage <input type="checkbox"/> Other: _____			
Individuals Requesting Coverage With This Form: <input type="checkbox"/> Employee OR <input type="checkbox"/> Spouse <input type="checkbox"/> Children (guaranteed) <input type="checkbox"/> Children (underwritten) <i>Note: If employee or spouse (not both) is applying when first eligible and coverage is approved, then the children's coverage is guaranteed. At all other times, children's coverage must be underwritten.</i>			

Employee OR Spouse Applicant Information (required)

Name (<i>last, first, middle initial</i>)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security #
Address (<i>street address, city, state, zip code</i>)		Telephone Work: _____ Home: _____	

Amounts Requested with this Form

Enter the **dollar** amount of current and/or guaranteed coverage. Enter the total **dollar** amount desired. The difference between these two columns is the **dollar** amount to be underwritten. For questions regarding proper amount to be underwritten, contact your Benefits person.

	Current/Guaranteed Amount	Total Amount Desired	Amount to be Underwritten
Employee: <input type="checkbox"/> Portable Life	\$ _____	\$ _____	\$ _____
OR Spouse: <input type="checkbox"/> Portable Life	\$ _____	\$ _____	\$ _____
Child(ren): <input type="checkbox"/> Dependent Life	\$ _____	\$ _____	\$ _____

Give Information Regarding Individuals Requesting Coverage With This Form

Names of persons applying with this form. <i>Please print full name.</i> (Last) (First)	Relationship to employee	Birthdate (mm/dd/yy)	Present Height (ft.) (in.)	Present Weight (pounds)	Regular physician(s) - provide name and complete mailing address (<i>attach sheet if needed</i>)
Employee	SELF				
OR Spouse					
Child					
Child					
Child					

Health Information for Employee or Spouse to be Underwritten

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you, for any condition during the past 12 months, consulted a physician, received surgical or medical care, or taken prescribed medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), AIDS related conditions, or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had, or been treated for nervous, brain or lung disorders, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury or other disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug use, or are you currently using illegal drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever applied for insurance that was declined, postponed or modified in any way? | <input type="checkbox"/> | <input type="checkbox"/> |

Health Information for Child(ren) to be Underwritten

Complete this section **only** if children must be underwritten (i.e. if coverage is **not** guaranteed).

- | | | | |
|-----|---|--------------------------|--------------------------|
| | | YES | NO |
| 6. | Is any child living away from home? <i>If yes, state which child(ren) and their address(es):</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Has insurance applied for on any child ever been declined, postponed or modified? <i>If yes, state which child, the reason and the date.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Has any child had or been advised to have any surgical operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Has any child ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), AIDS related conditions, or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Has any child ever had or been treated for nervous, brain or lung disorders, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury or other disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Is each child named above now in good health and free from injury, disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "yes" to any questions 1-5 or 8-10, or "no" to question 11, please give full details below. Attach additional sheets if needed.

Q #	Name of family member	Condition/illness/injury-type of treatment	Date of Treatment	Physician's name and complete mailing address <i>(include the medical or clinic ID number if any)</i>

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have provided on this form is complete and correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which may be a crime.
- I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, **(Employee)** provided I am actively at work; **(Spouse)** provided I am able to carry on all the normal and customary activities of a person of like age and sex who is in good health on that date.

Authorization and Acknowledgment:

For underwriting and claims purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc. (MIB), Social Security Administration or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Applicant's Signature (Employee OR Spouse) - required	Date
Signature of Parent of Proposed Insured Child (if other than applicant, AND children's coverage is not guaranteed)	Date
Signature of any Proposed Insured Child age 18 and over	Date