EMPLOYEES RETIREMENT SYSTEM OF TEXAS
Texas Employees Group Benefits Program (GBP)
Active/Dependent/Retired Employees
Evidence of Insurability (EOI) Application for Life Insurance

Evidence of Insurability (EOI) may be required to 1) enroll in, 2) add dependents to, or 3) increase some GBP insurance coverages.

Evidence of Insurability means that you must provide health history information. To be considered for coverage, the EOI Application (Form 75986) must be completed in its entirety, signed, dated, and returned to Minnesota Life. You and any dependent applying for coverage are required to answer medical questions. A paramedical exam may be required, as well as medical records from your doctor. Information about the paramedical exam can be found at http://portamedic.com/paramed.asp. The information you provide on the EOI Application and any additional information requested and received is subject to review and approval by Minnesota Life. **Coverage will either be approved or denied based on the information reviewed.**

GENERAL INSTRUCTIONS

Important: Write your agency name and agency number in the box at the top of the Application. If you need assistance in completing this section and **you are an active employee**, 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.) **If you are a retiree**, write ERS under Agency Name and write 0327 under Agency Number. Minnesota Life uses this information to communicate underwriting decisions of approval, denial, and file closure to Benefits Coordinators and ERS.

SECTION A: EMPLOYEE/RETIREE 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 employee identification number and current height/weight.

SECTION B: EMPLOYEE/RETIREE COVERAGE ADDITIONS AND CHANGES
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: DEPENDENT COVERAGE
Complete this section if you are applying for Dependent Life coverage for any of your dependent(s). Write the full name of any dependent applying for coverage and check the appropriate boxes. ***Important:*** To prevent processing delays, provide the last four digits of your Social Security Number and current height/weight for any person applying for coverage.

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

SECTION E: AGREEMENTS AND AUTHORIZATION
Please read the Agreements and Authorization before signing the Application. Your signature is required and must be legible. The signature of your spouse is required (if requesting insurance). 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 or fax the completed Evidence of Insurability Application (pages 2 - 5) to:

Minnesota Life Insurance Company
600 Congress Ave, Suite 2160
Austin, TX 78701
(877) 494-1716
Fax (512) 236-0199

Please do not return the completed form to your Benefits Coordinator.

Texas Employees Group Benefits Program
Group Life Insurance Evidence of Insurability Application
Active/Retired Employees

Minnesota Life Insurance Company - A Securian Company
600 Congress Avenue, Suite 2160 • Austin, TX 78701 • 877-494-1716 • Fax 512-236-0199

MINNESOTA LIFE

Employees Retirement System of Texas **POLICY NUMBER: 34023**

You must complete each page in full, and the application must be signed and dated on Page 5 to be considered. Please complete this application in black or blue ink. This form will not be considered unless received by Minnesota Life within 30 days of completion. Insurance that requires satisfactory evidence of good health will not be effective for an applicant unless, and until Minnesota Life accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

Return this application to Minnesota Life at the address above. Please do not return to your Benefits Coordinator. If you have questions, please call 1-877-494-1716.

To be completed by the Employee/Retiree. If applying for retiree coverage, please indicate ERS-0327.	
Agency Name	Agency Number

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

Last name	First name	Middle initial		Date of birth	☐ Employee ☐ Retiree ☐ Return-to-Work Retiree
Street address		City	Eligible county	State	Zip code
Gender ☐ Male ☐ Female	Height	Weight	ERS employee ID		Last 4 digits of SSN

Complete only one date:
Employee hire date:____/____/____ Retiree retirement date:____/____/____ Retiree return-to-work date:____/____/____

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

Reason: ☐ Annual Enrollment ☐ Qualified Life Event ☐ New Hire (Elections 3 or 4)

Employee Optional Life: ☐ Election Term 1 ☐ Election Term 2 ☐ Election Term 3 ☐ Election Term 4
Employee Dependent Life: ☐ Spouse - $5,000 ☐ Child - $5,000

Retiree Optional Life: ☐ $10,000 Term
Retiree Dependent Life: ☐ Spouse - $2,500 ☐ Child - $2,500

Section C: Dependent Coverage - If you are applying for insurance for your spouse and/or children, provide the following information. If additional space is needed, include a separate sheet and please sign and date it.

Relationship to Employee/Retiree	Name Last	First	MI	Last 4 digits of Social Security Number	Date of birth Mo./Day/Year	Height Ft./In.	Weight Lbs.
1. Spouse Marriage Date / /				XXX-XX-	/ /	/	
2. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
3. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
4. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
5. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
6. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
7. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
8. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
9. ☐ Daughter ☐ Son				XXX-XX-	/ /	/	
10. ☐ Other Specify_____				XXX-XX-	/ /	/	

MINNESOTA LIFE

Life EOI

Employee/Retiree Name: _____ Last 4 digits of SSN: _____

Section D: Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)

Check either **"Yes"** or **"No"** to each question and **circle the specific condition(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 investigation for fraud.**	Employee/ Retiree	Spouse	Child(ren)
1. Has any person applying for coverage been seen, treated, advised or received services from any health provider in the last 12 months, including routine physicals?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Has any person *for whom coverage is requested* 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	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No
c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia, dementia, Alzheimers, or any other mental/nervous/behavioral disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No
f. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign/malignant)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, Multiple Sclerosis, Parkinson's Disease or any other disease or disorder of the nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No
3. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including but not limited to AIDS, AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS virus (a positive HIV/Human Immunodeficiency test)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Currently or in the last 6 months, has any person applying for coverage taken medication (prescribed or otherwise), or been prescribed any medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Within the last 2 years, has any person applying for coverage 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 - 4?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Is any person applying for coverage currently pregnant? If **"Yes"**, indicate the anticipated delivery date_____. **Provide details of any current/ prior complications on Page 4.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Has any person applying for coverage 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	☐ Yes ☐ No	☐ Yes ☐ No

MINNESOTA LIFE

Life EOI

Employee/Retiree Name: _____ Last 4 digits of SSN: _____

Explanation of "Yes" answers in Section D - 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.	Person	Condition	Dates From/To	Hospitalized Yes/No	Surgery Yes/No	Treatment/ Medication	Current Medication/ Remaining Problems	Names/Addresses of Practitioners/Hospitals

MINNESOTA LIFE

Life EOI

Employee/Retiree Name:_____ Last 4 digits of SSN:_____

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; or may make a brief report of health information to the MIB. 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 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:

Minnesota Life Insurance Company
Group Division Underwriting
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

SECTION E: AGREEMENTS AND AUTHORIZATION - Please read carefully before signing

I, the undersigned applicant(s), 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, Minnesota Life Insurance Company 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 understand that coverage will be approved or denied only for those individuals listed on this Application. I also understand that incorrect, incomplete, or untrue or misleading answers on this Application may result in rescission of my coverage or that of my dependents, 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 the Company to consider this Application for me and each of my dependents and to make a determination on whether to accept and issue the coverage(s) applied for herein:

- If I refuse to sign this authorization, the Company has the right to deny my request for coverage or for that of my dependents, 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 the Company 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 those individuals listed on this Application will be sent to the applicant, or to the parent if the applicant is a child;
- 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 the Company.

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 the Company's underwriting department or its authorized representative(s) and ERS any information relating to me or my dependents 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.

Employee/Retiree signature X	Daytime telephone number	Evening telephone number	Date signed
Spouse/Dependent (over 18) signature X	Daytime telephone number	Evening telephone number	Date signed