Evidence of Insurability Cover Sheet

Please forward this cover sheet with your completed Evidence of Insurability form to
The Lincoln National Life Insurance Company at one of the following:
Mail – PO Box 2616 Omaha, NE 68103,
Fax – 877-573-6177 or Email – lfgenrollments@lfg.com

Group Name/Group ID:	Dublin City Schools/DUBLINCTY		
Date:		Employee Class:	
Employee Name:		Employee Billing Location:	
Spouse Name:		Employee Sort Group:	

Basic Coverage(s)		Current Amount of Coverage	Additional Amount of Coverage	Total Amount of Coverage
Life	☐	$_____	$_____	$_____
Dependent Life	☐	$_____	$_____	$_____
STD	☐	$_____	$_____	$_____
LTD	☐	$_____	$_____	$_____
LTD with Critical Illness	☐	$_____	$_____	$_____
Voluntary/Optional Employee Life	☐	$_____	$_____	$_____
Voluntary/Optional Employee Life & AD&D	☐	$_____	$_____	$_____
Voluntary/Optional Spouse Life	☐	$_____	$_____	$_____
Voluntary/Optional Spouse Life & AD&D	☐	$_____	$_____	$_____
Voluntary/Optional Short Term Disability (STD)	☐	$_____	$_____	$_____
Voluntary/Optional Long Term Disability (LTD)	☐	$_____	$_____	$_____
Critical Illness (Mark Categories Below)	**Enter Principal Sum for:**			
Heart Category Cancer Category Organ Category Quality of Life Category	☐ ☐ ☐ ☐	Employee $_____ Spouse $_____ Child $_____	Employee $_____ Spouse $_____ Child $_____	Employee $_____ Spouse $_____ Child $_____

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

EVIDENCE OF INSURABILITY INFORMATION

Please submit this form to The Lincoln National Life Insurance Company (herein referred to as "the Company"). No coverage for which evidence of insurability is required will be effective until approved in writing by the Company.

Complete all blanks in ink and print clearly. Incomplete forms will cause consideration for coverage to be delayed.

SECTION 1. Group Information:

Group Name	Group ID
Dublin City Schools	DUBLINCTY
Group Policy No(s).	Billing Division/Location

SECTION 2. Employee Information: (Complete even if employee is not applying for coverage.)

First Name_____ Last Name_____ Middle Initial_____

Social Security No. _____ State of Birth_____ Date of Birth ____ _____ _____

Annual Earnings $_____ Date of Hire/Rehire _____ _____ _____

Home Mailing Address:

_____ _____ _____ _____

(Street) (City) (State) (Zip)

Phone No(s): Home (_____) _____ _____ Work (_____) _____ _____ Best Time to Call _____AM/PM

Email Address:_____ Home ☐ Work ☐

Beneficiary (for Life or AD&D Insurance)_____ Relationship_____

SECTION 3. Spouse Information: (Complete only if applying for Dependent coverage.)

First Name_____ Last Name_____ Middle Initial_____

Social Security No. _____ State of Birth_____ Date of Birth ____ _____ _____

Home Mailing Address (if different than above):

_____ _____ _____ _____

(Street) (City) (State) (Zip)

Phone No(s): Home (_____) _____ _____ Work (_____) _____ _____ Best Time to Call _____AM/PM

Email Address:_____ Home ☐ Work ☐

SECTION 4. Plan(s) Applied for: (Only include the amount of coverage in excess of any existing amount or guaranteed issue amount.)

Basic Coverage(s)		Requested Basic Coverage Amount
Life	☐	$_____
Dependent Life	☐	$_____
STD	☐	
LTD	☐	
LTD with Critical Illness	☐	

Optional/Voluntary Coverage(s)		Requested Optional/Voluntary Coverage Amount
Employee Life	☐	$_____
Employee Life & AD&D	☐	$_____
Spouse Life	☐	$_____
Spouse Life & AD&D	☐	$_____
Short Term Disability (STD)	☐	$_____
Long Term Disability (LTD)	☐	$_____
Critical Illness (Mark Categories below)		**Enter Principal Sum for:**
Heart Category	☐	Employee $_____
Cancer Category	☐	Spouse $_____
Organ Category	☐	Child $_____
Quality of Life Category	☐	

STATEMENT OF HEALTH

SECTION 5. Medical Information - To be completed by applicants applying for ANY coverages.

Employee Applicant	Gender: ☐ Male	☐ Female	Height: _____Ft. _____In.		Weight: _____ lbs.			
Spouse Applicant	Gender: ☐ Male	☐ Female	Height: _____Ft. _____In.		Weight: _____ lbs.			

	Employee		Spouse	
	YES	NO	YES	NO
In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	☐	☐	☐	☐

SECTION 6. Medical Information - To be completed if applying for LIFE or DISABILITY coverages.

	Employee		Spouse	
	YES	NO	YES	NO
1. **Within the past 7 years**, have you had, or been told by a physician that you had, or been treated for a condition listed below? (**FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)**				
a. Heart or circulatory disorder; liver or kidney disorder; lung or respiratory disorder; mental or nervous disorder; alcoholism, drug or substance abuse; diabetes, cancer, tumor, epilepsy, hepatitis or stroke?	☐	☐	☐	☐
b. High blood pressure? If answered YES, please provide last reading and date of reading: BP Reading (Employee) _____ Date _____ BP Reading (Spouse) _____ Date _____	☐	☐	☐	☐
2. **Within the past 7 years**, have you been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)? (**FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)**	☐	☐	☐	☐
3. **Within the past 5 years,** have you been diagnosed with a physical disorder not listed above? (**IF ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.**)	☐	☐	☐	☐
4. Are you currently under observation, receiving treatment or taking medication? (**IF ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.**)	☐	☐	☐	☐
5. **If applying for DISABILITY coverage, please complete these additional questions.**				
a. Are you currently pregnant?	☐	☐	☐	☐
b. **Within the past 5 years,** have you been diagnosed or treated for:				
i. Disorder of the back, neck, or spine?	☐	☐	☐	☐
ii. Osteoarthritis, Rheumatoid Arthritis, or degenerative joint disease?	☐	☐	☐	☐
iii. Knee Disorder, Injury or Surgery?	☐	☐	☐	☐
(FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)				

SECTION 7. Provide details for any questions answered YES in SECTION 6. (Attach additional sheet, if needed.)

Question Number	Applicant Name	Condition/Treatment/Medication	Date of Diagnosis	Date of Last Symptom	Current Status or Condition	Attending Physician's Name, Address, and Phone Number

SECTION 8. Medical Information - To be completed if applying for CRITICAL ILLNESS coverage.	Employee		Spouse	
	YES	NO	YES	NO
1. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for Systemic Lupus, Type I or II Diabetes, or sarcoidosis?	☐	☐	☐	☐
2. **Within the past 7 years**, has anyone applying for coverage been diagnosed as having, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	☐	☐
If applying for the Heart Category, please complete the questions below.				
3. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for Pacemaker, any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?	☐	☐	☐	☐
4. Is anyone applying for coverage currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	☐	☐	☐	☐
If applying for the Cancer Category, please complete the question below.				
5. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for internal cancer, melanoma, bone marrow or stem cell transplant?	☐	☐	☐	☐
If applying for the Organ Category, please complete the question below.				
6. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor?	☐	☐	☐	☐
If applying for the Quality of Life Category, please complete the question below.				
7. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for glaucoma or retinitis pigmentosa?	☐	☐	☐	☐

FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I HEREBY:

1. request the coverage for which I am (or may become) or my Spouse is (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company;
2. authorize any required deductions from my earnings;
3. name the above beneficiary to receive any benefits payable in the event of my death;
4. represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed;
5. represent that if the above Statement of Health has been completed to obtain coverage for my Spouse, I have discussed and reviewed with my Spouse the responses and information supplied on behalf of my Spouse in the Statement of Health, and to the best of our knowledge and belief, the Spouse portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed; and
6. acknowledge that I have read the **FRAUD WARNING**.

I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue coverage as outlined in the contract. **The attached AUTHORIZATION has been completed and signed by the employee**.

Signature of (Employee) Applicant:_____ **Date:**_____

Signature of (Spouse) Applicant:_____ **Date:**_____

Group Insurance Service Office Use: ☐ Self Bill ☐ List Bill

Approved_____ Declined_____

EFFECTIVE DATE:_____

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or MIB, Inc. ("MIB") to release information from the records of:

1. Applicant/Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: _____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
   - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
   - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.

3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company or its reinsurers.

4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
   - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
   - as otherwise may be required by law or may be further authorized by me.

5. I authorize The Lincoln National Life Insurance Company, or its reinsurers, to disclose Protected Health Information or personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

6. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.

7. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

8. A photocopy of this Authorization is to be considered as valid as the original.

9. I acknowledge that I have received the attached Notice of Information Practices.

10. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant: _____ **Date:** _____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION
This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION
The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

We, or our reinsurers, may also release information in our 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.

MIB, Inc.
Information regarding your insurability will be treated as confidential. The Lincoln National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

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

Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL DISCLOSURE
Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW
After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS