Thank you for choosing CareFirst Diversified Benefits.

1. Complete EMPLOYER DETAILS and EMPLOYEE AND COVERAGE DETAILS on this page with information provided by your employer.
2. Complete the APPLICANT INFORMATION on pages 2–5.
3. Mail, fax or email completed form to: Medical Underwriting, P.O. Box 2993, Hartford, CT 06104; Fax: 866-822-8290; **medical.underwriting@groupclaims.com**

CareFirst Diversified Benefits

First Care, Inc. doing business as CareFirst Diversified Benefits

First Care, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117

EMPLOYER DETAILS	
Employer Name:	Employer Group Number:
Employer Mailing Address (Street, City, State, Zip Code):	
Division/Location/Subsidiary with Mailing Address (if applicable):	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone:

EMPLOYEE AND COVERAGE DETAILS			
Employee First Name	Middle Initial	Last Name	Date of Hire (mm/dd/yyyy):
Base Annual Earnings*:			Coverage Effective Date* (mm/dd/yyyy):
Applicant Name (if different than Employee):			
*As described in the contract with CareFirst Diversified Benefits (Base salary, Base salary plus commissions, W2, etc.)			

LIFE INSURANCE COVERAGE REQUESTED

- Enter the dollar amount of Current Life Coverage, including Guarantee Issue (GI) in Column A below. GI is the maximum amount of coverage (as defined in the contract with CareFirst Diversified Benefits) that does not require Evidence of Insurability (EOI). Please include Employee Basic Life coverage even if the employee is not requesting coverage at this time
- Enter the dollar amount of Life Coverage Subject to EOI in Column B below.

	A—Current Life Coverage, Including GI	B—Life Coverage Subject to EOI
Employee Basic Life	$	$
Employee Supplemental Life	$	$
Spouse Supplemental Life	$	$
Child Supplemental Life	$	$

DISABILITY INSURANCE COVERAGE REQUESTED

Check Yes if the employee is requesting Short Term Disability and/or Long Term Disability coverage that is subject to EOI:

Short Term Disability ◯ Yes, EOI is required

Long Term Disability ◯ Yes, EOI is required

Employee First Name | Middle Initial | Last Name

Applicant Name (if different than Employee)

Employer Name

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Evidence of Insurability

APPLICANT INFORMATION

If there are more than three Applicants, please provide the information on a separate sheet of paper.

Abbreviations: Employee = EE Spouse = SP Child = CH

First Name	Last Name	Social Security Number	EE	SP	CH	Gender (check one)	Height (ft./in.)	Weight (lbs.) *If currently pregnant, pre-pregnancy weight*	Date of Birth (mm/dd/yyyy)
			◯	◯	◯	◯ Male ◯ Female			
			◯	◯	◯	◯ Male ◯ Female			
			◯	◯	◯	◯ Male ◯ Female			

EE Address	Day Time Phone Evening Phone Email Address
SP Address ◯ same as EE	Day Time Phone Evening Phone Email Address
CH Address ◯ same as EE	Day Time Phone Evening Phone Email Address

MEDICAL INFORMATION

Each Applicant must answer each of the following questions to the best of their knowledge and belief. A Legal Guardian is required to answer each of the questions for minor children. If you have more than 1 child, specify which child(ren) the answer applies to on a separate sheet of paper.

	EE	SP	CH
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Are you currently pregnant?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Employee First Name | Middle Initial | Last Name

Applicant Name (if different than Employee)

Employer Name

MEDICAL INFORMATION

	EE	SP	CH
Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, been diagnosed or treated for drug or alcohol abuse (excluding support groups), or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

	EE	SP	CH		EE	SP	CH
Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Heart-Related Surgery or Heart Attack	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Muscular Dystrophy	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ Yes ◯ No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Stroke or transient ischemic attack (TIA)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Alzheimer's or Parkinson's Disease	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Paralysis	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Major Organ Transplant	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Depression	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Chronic Fatigue Syndrome or Fibromyalgia	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Sleep Apnea	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Narcolepsy	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Ulcerative Colitis or Crohn's Disease	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Kidney Failure or Dialysis	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

NOTICE

To the best of your knowledge, you are required to notify First Care, Inc. in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, First Care, Inc. may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, and copies of medical records which you have authorized us to review, and information obtained from MIB, Inc. Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Employee First Name | Middle Initial | Last Name

Applicant Name (if different than Employee)

Employer Name

AUTHORIZATION

I, an undersigned applicant, authorize First Care, Inc., together with its affiliates, ("Company") and/or its Third Party Administrator (TPA) to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company and/or its TPA to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company and/or its TPA by telephone.

◯ Yes you may leave a message as indicated above. ◯ No, please do not leave a message

In addition to the information that I have provided on this application, I authorize the Company and/or its TPA to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company and/or its TPA. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, MIB Group, Inc. (MIB, Inc), pharmacy or pharmacy benefits manager that possesses my protected personal health information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), to furnish such protected health information to the Company or its representative. The Company and/or its TPA may only use information disclosed under this authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I authorize the Company and/or its TPA to disclose the "PHI" in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

I/We authorize First Care, Inc., or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I agree that a photocopy of this authorization is valid as the original and I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to the Company and/or its TPA, and will not remain valid beyond the date the revocation is received by the Company and/or its TPA. I understand the revocation may be a basis for denying my insurance application, and that it does not alter the Company's and/or its TPA's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

FRAUD

For any Applicants that do not reside in the following states: Colorado, California, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee and Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of California: For your protection, California law requires the following to appear on this form: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee First Name | Middle Initial | Last Name

Applicant Name (if different than Employee)

Employer Name

FRAUD

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine and Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New York (applicable to Accident and Health Insurance only): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED THE STATE LAW.

PRE-EXISTING CONDITIONS LIMITATION—applicable to Accident and Health Insurance only—for residents of NY
With respect to group disability insurance, I understand that the policy/certificate may include a pre-existing condition provision that limits or excludes coverage for a period of time if I have a pre-existing condition as defined on the date my coverage becomes effective. I also understand that I may obtain additional information regarding this provision by referring to the group policy and/or certificate.

CERTIFICATION

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

Employee Signature	Date Signed
Spouse Signature	Date Signed
Child Signature (Parent/Legal Guardian of the Child is required to sign when submitting dependent Evidence of Insurability on a minor child.)	Date Signed

Please mail, fax or email the completed **Evidence of Insurability** application to:

Medical Underwriting, P.O. Box 2993, Hartford, CT 06104

Fax: 866-822-8290 medical.underwriting@groupclaims.com

Submit Form