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, Route 6999, Minneapolis, MN 55440.

Name of Employer/Plan Sponsor Southern Illinois University	Group/Plan Number 65708-5	Account Number/Location 1 – Carbondale/Springfield	Employee's Date of Hire
Name and phone number of the Benefits person in the Human Resources Department: Name: Phone ( ) Ext:		Employee's Name (print):	
This form needed due to: (check all that apply) ___Change in Coverage Amount ___Late Entrant *(enrolling after the 1st available opportunity)* ___ Initial Eligibility Following Hire ___Add Dependent Coverage ___Other: _____			
Individuals Requesting Coverage With This Form: ___Employee OR ___Spouse ___Children (guaranteed) ___Children (underwritten) *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.*			

Employee OR Spouse Applicant Information (required)

Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security # __ __ __ - __ __ - __ __ __ __
Address *(street address, city, state, zip code)*		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: ☐ Portable Life	$_____	$_____	$_____
OR Spouse: ☐ Portable Life	$_____	$_____	$_____
Child(ren): ☐ Dependent Life	$_____	$_____	$_____

Give Information Regarding Individuals Requesting Coverage With This Form

Names of persons applying with this form. *Please print full name.* (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 *(attach sheet if needed)*
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?	❒	❒
2.	Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?	❒	❒
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?	❒	❒
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?	❒	❒
5.	Have you ever applied for insurance that was declined, postponed or modified in any way?	❒	❒

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? *If yes, state which child(ren) and their address(es):* _____	❒	❒
7.	Has insurance applied for on any child ever been declined, postponed or modified*? If yes, state which child, the reason and the date*._____	❒	❒
8.	Has any child had or been advised to have any surgical operation?	❒	❒
9.	Has any child ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?	❒	❒
10.	Has any child ever had or been treated for nervous, brain or lung disorders, disorder of the immune system, 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?	❒	❒
11.	Is each child named above now in good health and free from injury, disease or disorder?	❒	❒

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 (*include the medical or clinic ID number if any*)

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 is 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 claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc.(MIB), employer or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf, ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical 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 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