The Lincoln National Life Insurance Company
Medical Underwriting, P.O. Box 2870, Omaha, NE 68103-2870
Phone: 800-423-2765 Fax: 603-427-1825
Email: EOIDocuments@lfg.com

EVIDENCE OF INSURABILITY

Based on your Employee benefit selections, we need more information from you. Please complete and return this entire form to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company). We ("the Company") use this form, known as evidence of insurability, to gather additional medical information. This information helps us evaluate your application for insurance or an increased amount of insurance. The insurance that requires this form will not be effective until we send you a written approval.

Print clearly in ink. An incomplete application will delay processing.

Employer Information	
Group Name: Duke University	Group ID/Number: 01-259835
Billing Group or Location:	Sort Group:
Policy #(s): SA3-810-259835-01	

Reason for Application: ☐ Annual Enrollment ☐ Initial Enrollment ☐ Change in Family Status
☐ Salary or Pay Increase ☐ Late Entrant (person requesting insurance after initial eligibility)
☐ New Hire (newly eligible) ☐ Updating benefits outside enrollment period ☐ Other_____

A. Applicant Name (Employee) Insurance Information – Required.

First Name _____ MI _____ Last Name _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Birth State _____ Employee ID _____

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ ZIP Code _____

Cell Phone (___) _____ Home Phone (___) _____ Work Phone (___) _____ Best Time To Call _____AM/PM

Email Address _____

Sex at Birth: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Domestic Partnership ☐ Civil Union

Employment Information: ☐ Full-Time ☐ Part-Time Employee Occupation:_____

Earnings: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual $_____ Date of Hire: ___/___/___

Is the Employee Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/___

Mark the box or boxes for each type of group insurance you are applying for and fill in the amount of insurance you are requesting. Your Employer can help you fill out this section. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate. For a Domestic Partner or Civil Union Partner applicant, complete information labeled "Spouse."

Type of Group Insurance	Current Amount	Additional Amount	Total Amount
☐ Basic Life (Employee)	$_____	$_____	$_____
☐ Dependent Life (Spouse)	$_____	$_____	$_____
☐ Dependent Life (Child)	$_____	$_____	$_____
☐ Dependent Life (Family)	$_____	$_____	$_____
☐ Short-Term Disability (STD)	$_____	$_____	$_____
☐ Long-Term Disability (LTD)	$_____	$_____	$_____
☐ Voluntary Life (Employee)	$_____	$_____	$_____
☐ Voluntary Life (Spouse)	$_____	$_____	$_____
☐ Voluntary Life (Child)	$_____	$_____	$_____
☐ Voluntary Life (Family)	$_____	$_____	$_____
☐ Voluntary Short-Term Disability (STD)	$_____	$_____	$_____
☐ Voluntary Long-Term Disability (LTD)	$_____	$_____	$_____

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B. Applicant Dependent (Spouse, Domestic Partner, Civil Union Partner) and/or Child(ren) Information. Only complete if applying for Dependent insurance. (Attach additional sheet, if needed.)

	First Name	MI	Last Name	Social Security Number	Date of Birth	Sex at Birth	Birth State
Spouse:				___-___-____	___/___/____	☐ M ☐ F	
Child:				___-___-____	___/___/____	☐ M ☐ F	
Child:				___-___-____	___/___/____	☐ M ☐ F	
Child:				___-___-____	___/___/____	☐ M ☐ F	
Child:				___-___-____	___/___/____	☐ M ☐ F	

Provide contact information if different than the Employee information above.

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ ZIP Code _____

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____ Best Time To Call _____AM/PM

Email Address _____

STATEMENT OF HEALTH

C. Medical Information – Applicants complete if applying for ANY insurance.

	Height	Weight		Height	Weight
Employee:	_____ft_____in.	_____lbs.	**Child:**	_____ft_____in.	_____lbs.
Spouse:	_____ft_____in.	_____lbs.	**Child:**	_____ft_____in.	_____lbs.
Child:	_____ft_____in.	_____lbs.	**Child:**	_____ft_____in.	_____lbs.

	Employee		Spouse		Child	
	Yes	No	Yes	No	Yes	No
1. I understand that the Company is relying on the information that I provide in this form in order to evaluate my application for insurance. I understand that any incorrect information or information not disclosed in this application could result in underwriting delays, loss of benefits, or non-payment of claims.	☐	☐	☐	☐	☐	☐
2. Within the past 12 months, has anyone applying for insurance used any form of tobacco or nicotine products (includes cigarettes, cigars, chewing tobacco, vaping, e-cigarettes, and nicotine supplements like gum and patches)?	☐	☐	☐	☐	☐	☐

D. Medical Information – Applicants complete if applying for Life or Disability insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay. Child refers to all Dependent Children Applicants.

1. **Within the past 5 years,** to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with, consulted, or treated by a licensed member of the medical profession for any of the following diseases, illnesses, or conditions:	Employee		Spouse		Child	
	Yes	No	Yes	No	Yes	No
a. Heart disease, heart condition, or symptoms related to the heart, vascular or circulatory disease, hypertension/high blood pressure, history of stroke, mini-stroke, or Transient Ischemic Attack (TIA)?	☐	☐	☐	☐	☐	☐
b. Cancer or tumor (exclude basal cell carcinoma), chronic lung disease or disease of the respiratory system, chronic liver disease or disorder of the liver, diabetes, chronic digestive disorder, chronic kidney disease or disorder?	☐	☐	☐	☐	☐	☐
c. Chronic neurological disease or disease of the brain or nervous system, disease or disorder of the blood or immune system, Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS), mental or cognitive disorder, alcohol or drug abuse, depression or anxiety? **Note: AIDS is a medical condition caused by HIV infection.**	☐	☐	☐	☐	☐	☐
d. Disorder or chronic disease of the back, neck, spine, knee, hip, shoulder, wrist, arthritis, degenerative joint disease, injury or damage to muscles or ligaments, chronic pain, currently pregnant, or missed work or school for more than 7 consecutive days due to any disease, illness, or condition?	☐	☐	☐	☐	☐	☐

If a question was answered YES in SECTION D, then you must complete SECTION E below.

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E. Additional Details

Provide details for any questions answered YES in SECTION D. (Attach additional sheet, if needed.)					
Question Number	**Applicant Name**	**Condition/Diagnosis**	**Treatment/Names of Medication**	**Date of Diagnosis & Medication Prescribed Date(s)**	**Are You Currently Being Treated?**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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EVIDENCE OF INSURABILITY
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F. Fraud Warning/State Disclosure(s)

ANY PERSON WHO, WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE AN INSURER OR INSURANCE CLAIMANT: (1) PRESENTS OR CAUSES TO BE PRESENTED A WRITTEN OR ORAL STATEMENT, INCLUDING COMPUTER-GENERATED DOCUMENTS AS PART OF, IN SUPPORT OF, OR IN OPPOSITION TO, A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR MATTER MATERIAL TO A CLAIM, OR (2) ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER PERSON TO PREPARE OR MAKE ANY WRITTEN OR ORAL STATEMENT THAT IS INTENDED TO BE PRESENTED TO AN INSURER OR INSURANCE CLAIMANT IN CONNECTION WITH, IN SUPPORT OF, OR IN OPPOSITION TO, A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS FALSE OR MISLEADING INFORMATION CONCERNING A FACT OR MATTER MATERIAL TO THE CLAIM IS GUILTY OF A CLASS H FELONY.

G. Acknowledgements

1. I request the insurance for which I am (or may become) or my Spouse or Child(ren) is (or may become) eligible under group policies issued by the Company;
2. I authorize any required deductions from my pay;
3. I 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;
4. I represent that if the above Statement of Health has been completed to obtain insurance for my Spouse and Child(ren), I have discussed and reviewed with my Spouse and Child(ren) the responses and information supplied on behalf of my Spouse and Child(ren) in the Statement of Health, and to the best of our knowledge and belief, the Spouse and Child(ren) portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed;
5. I acknowledge that I have read the **Fraud Warning/State Disclosure(s)**;
6. I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue insurance as outlined in the contract; and
7. **The attached AUTHORIZATION FOR RELEASE OF INFORMATION has been completed and signed by me (Employee Applicant). A separate AUTHORIZATION FOR RELEASE OF INFORMATION has been completed and signed by the (Spouse) Applicant, and by the (Child) Applicant, if required.**

Signature of (Employee) Applicant: **X**_____ Date: ____/____/____

Signature of (Spouse) Applicant: **X**_____ Date: ____/____/____

Signature of (Child) Applicant: **X**_____ Date: ____/____/____
(Required only if applying for Dependent insurance and the Child Applicant is over the age of majority of the state in which the Child Applicant resides.)

If an Agent assisted in the completion of this application form, the agent must sign below.
I, the Agent, certify that I have truly and accurately recorded on the application form the information supplied by the applicant.

Agent's Signature: **X**_____ Date: ____/____/____

PLEASE COMPLETE THE ATTACHED AUTHORIZATION FOR RELEASE OF INFORMATION (EACH APPLICANT IS REQUIRED TO COMPLETE AND SIGN AN "AUTHORIZATION FOR RELEASE OF INFORMATION" FORM)

Return all pages to avoid processing delays.

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AUTHORIZATION FOR RELEASE OF INFORMATION

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 (the 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.

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 insurance 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: X_____ **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 on a fair and equitable basis, we must collect information about you and others for whom insurance 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, 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