GUARDIAN

# Online Health Questions

1 Select Coverage → 2 Personal Information → 3 Health Information → 4 Review

## Step 1 : Select Coverage

* required

### Welcome to Online Health Questions

In order to obtain coverage you will be required to complete simplified health questions. You also may be required to complete more detailed health questions (Evidence of Insurability) if necessary

To complete this process, you may need to provide:

- Group ID/Plan Number
- Coverage(s) being requested
- Health history/Doctor information
- Current insured amount
- Additional amount being requested

Customer is welcomed to the Online Health Questionnaire. Additional information that may be required for processing the EOI request is presented at this time.

If applying for dependent coverage, you may need to provide their:

- Date of Birth
- Height
- Weight
- Health history/Doctor information
- Current insured amount
- Additional amount being requested

FAQ link opens a page where general EOI process questions are answered

To help you understand the Online Health Questions process, please read our FAQ's. haga clic aquí para 'preguntas más frecuentes' en español

Before you can begin the Online Health Questions Process, you must indicate that you have read the Disclosure Statement below.

☑ **Yes**, I have read and agree to the Disclosure Statement.

The Customer must read and agree to the Disclosure Statement

**Group ID/Plan Number:** * 00527382

**Planholder Name (Company Name):** EDI

**Coverage(s) you are requesting:** *

☑ Basic Life (Employer Sponsored Coverage)

**Who is applying for coverage?** * (Select all that apply.)

☑ **Employee**

Current insured amount: $ 100000

Additional amount being requested: $ 50000

☑ **Spouse**

Current insured amount: $ 50000

Additional amount being requested: $ 25000

☑ **Child(ren)**

Current insured amount: $ 10000

Additional amount being requested: $ 6000

Selected employee and dependent benefit amounts are pre populated for each coverage when connected to a BenAdmin partner/TPA or GA. These values are not editable.

☑ Voluntary Life (Employee Paid Coverage)

**Who is applying for coverage?** * (Select all that apply.)

☑ **Employee**

Current insured amount: $ 100000

Additional amount being requested: $ 50000

☑ **Spouse**

Current insured amount: $ 50000

Additional amount being requested: $ 25000

- [x] **Child(ren)**
  - Current insured amount: $ 10000
  - Additional amount being requested: $ 5000
- [ ] Cancer
- [x] Critical Illness

  **Who is applying for coverage?** * (Select all that apply.)

  - [x] **Employee**
    - Current insured amount: $ 5000
    - Additional amount being requested: $ 25000
  - [x] **Spouse**
    - Current insured amount: $ 5000
    - Additional amount being requested: $ 5000
- [x] Voluntary Critical Illness

  **Who is applying for coverage?** * (Select all that apply.)

  - [x] **Employee**
    - Current insured amount: $ 20000
    - Additional amount being requested: $ 5000
  - [x] **Spouse**
    - Current insured amount: $ 5000
    - Additional amount being requested: $ 5000
- [x] Short Term Disability
  - Current insured amount: $ 1000
  - Additional amount being requested: $ 500
- [x] Long Term Disability
  - Current insured amount: $ 10000
  - Additional amount being requested: $ 5000

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CONTINUE

Clicking "Continue" will bring you to step 2: Personal Information

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# Online Evidence of Insurability

The FAQ link opens this page where a long list of potential questions are answered. This link is only presented in step 1 of the EOI application.

## Frequently Asked Questions

**Question: What is the difference between online health questions and evidence of insurability?**

- Online health questions are simplified health questions that are required to obtain a certain amount of coverage. Evidence of insurability questions are more detailed health questions that are required to obtain coverage.
- Depending upon how your plan was sold, you will see simplified health questions before you may be required to complete more detailed health questions (Evidence of Insurability).

**Question: What is evidence of insurability?**

- Evidence of Insurability (EOI) is an application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage. The completed evidence of insurability application requires review and approval by Guardian Life before coverage becomes effective.

**Question: Why is evidence of insurability used?**

- EOI is utilized to protect an employer's group insurance program from adverse risks and reduce the likelihood of disproportionate claims risks. This helps the employer's utilization and controls the costs of their insurance program.

**Question: When is evidence of insurability required?**

- When coverage exceeds the Guaranteed Issue amount, when an applicant increases the current coverage, or if an applicant is a late entrant.

**Question: Who is an applicant?**

- An employee, spouse, or child, who exceeds the Guaranteed Issue amount, increases existing coverage, or is a late entrant.

**Question: What is a late entrant?**

- An applicant who either initially waived coverage or who is now more than 31 days past the eligibility date.

**Question: What is the Guaranteed Issue amount?**

- Maximum benefit an on-time entrant applicant can receive without completing evidence of insurability coverage.

**Question: What does the online evidence of insurability application consist of?**

- Online EOI allows employees to submit their EOI application electronically via our secured internet site.

**Question: Do I have to complete my evidence of insurability online?**

- No, you may download a copy of the form, complete with pen, and send to Midwest Regional Office, P.O. Box 14319, Lexington, KY 40512 or attach to an email and send to AppletonBilling@glic.com.

**Question: What information will I need before I start the online application process?**

- You will need to know the amount of insurance currently inforce, and the additional amount you are now requesting. If you are unsure of this information, you should contact your employers insurance plan administrator.

- You will need current height and weight of all applicants requiring evidence of insurability. You will need to have full names and addresses of your medical providers and hospitals if applicable, dates and description of treatment, and degree of recovery. The more complete your information is on your initial application, the less likely we will have to follow up with you seeking clarification.

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**Question: Is my medical history / information secure and confidential?**

- The Guardian will use the information obtained by authorization / e- signature to determine eligibility for insurance or eligibility for benefits under this plan. Guardian will not release any information obtained to any person or organization except to Reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with this application, claim or as may be lawfully permitted or required. All measures have been taken to make sure your medical history is secure and confidential under Privacy legislation and is HIPAA compliant.

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**Question: Will additional medical requirements be required?**

- During the underwriting process and based upon the volume applied for and medical history on the evidence of insurability form, additional medical requirements may be needed. This could include an exam or lab testing, medical records, or a telephone interview.

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**Question: How long will the underwriting process take?**

- That could vary on each application. If no additional underwriting is necessary, 5 - 7 business days. If additional underwriting needed such as testing, medical records, or a telephone interview, possibly 3 - 4 weeks.

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**Question: How will I be notified of the underwriting decision?**

- You will be sent a letter to your home address. Your plan administrator will also be notified with a copy of this correspondence.

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**Question: If I am declined for coverage, how will I be notified?**

- You will be sent a letter to your home address of the declination. Because your plan administrator will be sent a copy of this correspondence, the reason for this adverse decision will not be included in this letter. Additional instructions will also be sent on how to find out the specific reasons for declination. After receiving this information, you may appeal this decision in writing.

# Member Disclosure Statement

The Disclosure Statement link brings the customer to our member disclosure statement shown here:

If electing or changing benefits using this site, you acknowledge that the information you enter will be used for enrollment purposes and additional information may be requested in order to complete the enrollment process. Additionally, you agree to the terms of the insurance contract that governs your plan, if any. In the event any conflicts and/or discrepancies exist between the information on this site and your group insurance plan(s), if any, the terms of the contract will prevail.

# Online Health Questions

1 Select Coverage → 2 Personal Information → 3 Health Information → 4 Review

## Step 2: Enter Personal Information

* required

**Group ID/Plan Number:** 00527382
**Planholder Name (Company Name):** EDI

### Employee Information

| | Last Name * | First Name * | Middle Initial |
|---|---|---|---|
| **Name** * | SNMMMMTESTCASEIZ | YOLANDA | A |

**Employee Social Security Number:** * 844 45 1237
**Gender:** * Female
**Date of Birth:** * 07/31/1970
**Place of Birth (State):** * New Jersey
**Height:** * 5 Feet 8 Inches
**Weight:** * 130 Pounds

Personal Information for employee and dependents will be pre populated based on the information provided during enrollment. These values are not editable.

At this time the customer is required to enter their height and weight information in addition to their dependents height and weight.

If you need to make a change to your address. Please contact your plan administrator.

**Employee Address:** * 1901 63RD STREET
**City:** * Richmond
**State/Province:** * Virginia
**Zip Code:** * 27601
**Country:** * USA
**Home Phone Number:** 303 456 9544
**Cell Phone Number:** 303 778 3366
**Email Address:(Review and update email address. Used for insurance purposes only.)** ramya_prabhu@glic.com
**How Best to Contact:** *
- (•) Home Phone Number
- ( ) Cell Phone Number
- ( ) Email Address

### Spouse Information

| | Last Name * | First Name * | Middle Initial |
|---|---|---|---|
| **Name** * | SNMMMMTESTCASEMP | OSWELL | |

**Gender:** * Male
**Date of Birth:** * 05/31/1970
**Height:** * 5 Feet 11 Inches
**Weight:** * 190 Pounds

### Child Information

| | Last Name * | First Name * | Middle Initial |
|---|---|---|---|
| **Name** * | SNMMMMTESTCASEIZ | Nulla | |

**Gender:** * Female
**Date of Birth:** * 03/20/2000

**Height:** * 4 Feet 11 Inches

**Weight:** * 95 Pounds

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PREVIOUS PAGE CONTINUE

Clicking "Continue" will bring you to page 3: Enter Health Information

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# Online Health Questions

1 Select Coverage → 2 Personal Information → 3 Health Information → 4 Review

**Step 3 : Enter Health Information**

* required

**Group ID/Plan Number:** 00527382
**Planholder Name (Company Name):** EDI

## Employee - SNMMMMTESTCASEIZ, YOLANDA, A - Risk Assessment

100 %

At this time the employee is required to answer a series of conditional questions regarding their past and current medical conditions

**Please answer the following questions:**

| | | | |
|---|---|---|---|
| In the last 6 months have you or any of your dependents received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; or any other Chronic Condition? Have you or any of your dependents ever been diagnosed with, treated for or received testing related to AIDS or AIDS Related Complex (ARC) by a physician or appropriately licensed clinical professional acting within scope of his/her license? | No | Change Answer | ✓ |
| 1. In the past 10 years, has any proposed insured been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart; liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition; d) auto immune disorder, e) diabetes; f) cancer, or g) a stroke? | Yes | Change Answer | ✓ |
| | Cancer | Remove | ✓ |

A "yes" response will prompt additional questions to populate regarding the type of medical condition, its onset, the duration, treatment, and amount of recovery

### Cancer

| | | | |
|---|---|---|---|
| When did the condition start (month/year)? | 09/2010 | Change Answer | ✓ |
| What is the duration of your condition? | 1 year | Change Answer | ✓ |
| What is your treatment? | chemo and radiation | Change Answer | ✓ |
| Did you attend a physician in relation to your Cancer? | Yes | Change Answer | ✓ |

### Cancer Physicians ✓

**Dr. Pepper**
**Wellness**
**Illinois**
**United States of America**

Edit Remove

The employee will also be asked to provide information of the Doctor who oversaw their treatment

| | | |
|---|---|---|
| Did any other physician treat you for your Cancer? | No | Change Answer |

| | | | |
|---|---|---|---|
| | | Add Another | |
| 2. In the past 5 years, has any proposed insured: used any illegal drugs; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised to seek treatment for alcoholism, drug abuse or drug dependency? | No | Change Answer | |
| 3. Has any proposed insured ever tested positive for HIV (Human Immunodeficiency Virus) antibodies? | No | Change Answer | |
| 4. In the past year, has any proposed insured: (a) consulted or been examined by or treated by a physician, practitioner or specialist for any illness or injury, disease or disorder NOT listed in the questions above (include routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment or a consultation in a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X ray, blood work, ultrasound, an MRI, a CT scan, or PET scan with abnormal findings; or been prescribed medication(s) - (other than for colds, flu or allergies)? | No | Change Answer | |
| 5(a). If applying for disability coverage, please complete these questions: (a) In the past 5 years, has any proposed insured been treated for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition? | No | Change Answer | |
| 1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ, malignant melanoma, tumor (benign or malignant), Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD, pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant? | No | Change Answer | |
| 2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack, heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions or treatment for coronary arteries? | No | Change Answer | |
| 3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months or been diagnosed with or treated for diabetes (except if present only in pregnancy)? | No | Change Answer | |

If you have electing dependents the "Continue" button will bring up the same series of conditional questions for each electing dependent. After all of the dependents medical questions are answered the "Continue" button will bring you to stet 4: Review

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# Online Health Questions

1 Select Coverage → 2 Personal Information → 3 Health Information → 4 Review

## Step 4 : Review the information and select "Submit"

* required

Take another look at the information you provided. You can make changes as needed.

**Group ID/Plan Number:** 00527382
**Planholder Name (Company Name):** EDI

### Sign Your Online Health Questions

To complete the Online Health Questions Process, you must indicate that you read the documents below. You must also electronically sign your Evidence of Insurability Form by providing the last 4 digits of employee's Social Security Number and employee's Last Name

- ☑ **Yes**, I have read and agree to the Consent Statement
- ☑ **Yes**, I have read and understand the Declarations and Authorizations

At this time the employee must read and agree to the Consent Statement and Declarations and Authorizations.

I have read and completed the Evidence of Insurability Form and declare that all information is true and complete to the best of my knowledge and belief. I understand that this information will be used by Guardian to help determine my insurability for enrollment purposes and/or for the ongoing administration of it's products. I have read and acknowledge the entire contents of this Evidence of Insurability Form, and the documents displayed on this page. I understand that by entering the last 4 digits of employee's Social Security Number and employee's Last Name and clicking on the "Submit" Button below, I am signing and submitting the Evidence of Insurability Form to Guardian. This is a legally binding electronic signature.

**Sign this Evidence of Insurability by typing in the last 4 digits of employee's Social Security Number and employee's Last Name.**

**Enter Last 4 Digits of Employee's Social Security Number:** 1237

**Enter Employee's Last Name:** SNMMMMTESTCASEIZ

The employee must enter the last four digits of their Social Security Number and their Last name as their electronic signature.

To complete the Online Health Questions Process, you must indicate that you have read the documents below. You must also electronically sign your Evidence of Insurability Form by providing the spouse's Date of Birth and spouse's Last Name.

- ☑ **Yes**, I have read and agree to the Consent Statement
- ☑ **Yes**, I have read and understand the Declarations and Authorizations

The Spouse must also read and agree to the Consent Statement and Declarations and Authorizations.

I have read and completed the Evidence of Insurability Form and declare that all information is true and complete to the best of my knowledge and belief. I understand that this information will be used by Guardian to help determine my insurability for enrollment purposes and/or for the ongoing administration of it's products. I have read and acknowledge the entire contents of this Evidence of Insurability Form, and the documents displayed on this page. I understand that by entering the spouse's Date of Birth and spouse's Last Name and clicking on the "Submit" Button below, I am signing and submitting the Evidence of Insurability Form to Guardian. This is a legally binding electronic signature.

**Sign this Evidence of Insurability by typing in the spouse's Date of Birth and spouse's Last Name.**

**Enter Spouse's Date of Birth (MM/YYYY):** 05/1970

**Enter Spouse's Last Name:** SNMMMMTESTCASEIZ

The Spouse must enter their Date of Birth and their last name as their electronic signature.

Clicking "Submit" will bring you to our application submission "Thank You" page

SUBMIT

### Personal Information

CHANGE

[+] View Personal Information Detail

### Health Information

CHANGE

[+] Employee - SNMMMMTESTCASEIZ, YOLANDA, A

At this point the employee is given one final opportunity to change and adjust any of the personal and health information provided in the EOI form.

[+] **Spouse - SNMMMMTESTCASEMP, OSWELL**

[+] **Child - 1- SNMMMMTESTCASEIZ, Nulla**

# Online Health Questions

## Thank You

**Group ID/Plan Number:** **00527382**
**Planholder Name (Company Name):** **EDI**

You have completed the Online Health Questions Process. Your application has been referred to our Group Underwriting Department.

Guardian will now review your Health Questions and notify you when the review is complete.

**Insurance You Applied For:**

- Employee Basic Life Insurance
- Spouse Basic Life Insurance
- Child(ren) Basic Life Insurance
- Employee Voluntary Life Insurance
- Spouse Voluntary Life Insurance
- Child(ren) Voluntary Life Insurance
- Employee Critical Illness Insurance
- Spouse Critical Illness Insurance
- Employee Voluntary Critical Illness Insurance
- Spouse Voluntary Critical Illness Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance

The employee receives verification that the Online Health Questionnaire process for their elected coverages is complete and will be reviewed by our underwriting department.

### What should you do now?

We recommend you download and print this PDF copy of your Health Questions Form.

The employee is recommended to download and print a copy of their submitted Health Questions Form.

### What happens next?

Your application will be forwarded to our Group Underwriting department. Underwriters will begin the review process, and you will be contacted shortly if additional information is needed. Once the process is finalized, a decision letter will be mailed to your home address. A copy of the decision letter will also be mailed to your employer.

If you are already a member with Guardian Insurance, sign up for our secure website www.guardianantytime.com. You can track status of your application within 24-48 hours. If you have further questions, please contact our Customer Response Unit (CRU) at 1-888-278-4542.

"What happens next?" provides information about the remainder of the EOI process and how the applicant can track the status of their insurance eligibility.