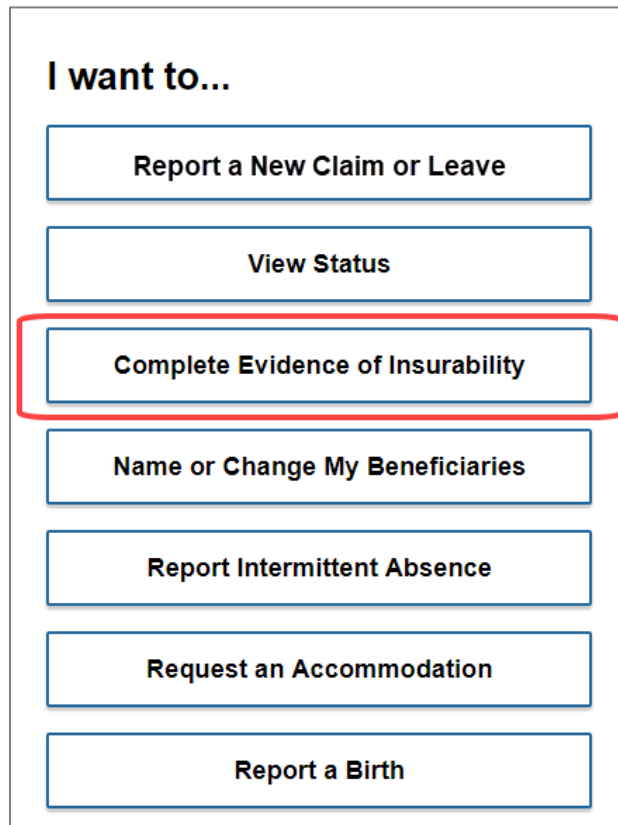


## About This Guide

The links and functionality described in this guide are based on the assumption that you have logged into the secure portal and are on the Employee Homepage.

## Introduction

The Evidence of Insurability (EOI) functionality allows you to complete an online application for new insurance coverage or when changes in coverage has been made. This feature can be accessed by selecting **Complete Evidence of Insurability** on the Employee Homepage. (It may say **Statement of Health**)



**I want to...**

- Report a New Claim or Leave
- View Status
- Complete Evidence of Insurability**
- Name or Change My Beneficiaries
- Report Intermittent Absence
- Request an Accommodation
- Report a Birth

NOTE: Your homepage may look slightly different than the image above.

# Getting Started

Before you get started, please keep the following in mind:

- To change the language to Spanish, click *En Espanol* in the top right-hand corner of the page.
- You will need Adobe Reader to view the confirmation report.
- For added security the portal has a 20-minute timeout feature.
- Time to complete the application may vary. However, you will have the option to save it for later during the application process.

The “Getting Started” page provides important information about the application, why we need this information, and what is needed for the online application. Before starting, please take a few minutes to collect all the necessary information about yourself or the applicant you wish to add or manage.

- Name
- Date of Birth
- Height and Weight
- If applicable: Medications Prescribed & Date First Prescribed, Diagnosis, Treatment, and Treating Health Professional

Once you are ready to begin the online application, please verify your identity based on criteria from your employer and begin the application.

[Home](#) [Forms](#) [Learn More](#)

## Evidence of Insurability (EOI)

Get Started Applicant Info Qualifying Info Review Signature

**Getting Started** [Get Help](#)

### Why we need this information

You recently requested to add or change your coverage. As part of this change, you are required to provide medical information.

### What you will need for each applicant applying for coverage

Information about:	You will need their:
<ul style="list-style-type: none"><li>• You</li><li>• Your Spouse/Domestic Partner</li><li>• Your Child or Children</li></ul>	<ul style="list-style-type: none"><li>• Name</li><li>• Date of Birth</li><li>• Height and Weight</li></ul>

If any of the applicants have a disease or condition and/or take prescription medications, you will also need their:

<ul style="list-style-type: none"><li>• Diagnosis</li><li>• Treatment</li><li>• Treating Health Professional</li></ul>	<ul style="list-style-type: none"><li>• Medications Prescribed</li><li>• Date First Prescribed</li></ul>
--	--

### What you will do

Verify your identity and start the application

Employee ID

Employee SSN (without dashes)

[Verify Your Identity & Start](#)

### Need help?

If you have any coverage questions, please contact your employer or benefit plan administrator.

**Quick Tip**  
All questions will need to be answered to complete the application process.

### Notes

- The time to complete filling out the application will vary. However, you will have the option to **save it for later**.
- Important: Use the **Go Back** and **Continue** buttons to navigate between screens. Do not use the navigation options in your web browser.
- For added security, this site has a **time-out** feature. Your session will automatically end following 15 minutes of inactivity to protect your personal information.

# Applicant Information

The Application Information page collects basic information to begin the EOI application. Enter information about why you are filling out the application, which coverage/benefits are applicable, and your personal and contact information. Some information for you and your dependents may be pre-filled, if already provided by your employer.

When finished entering applicant information, select **Continue**.

Home Forms Learn More

## Evidence of Insurability (EOI)

Get Started Applicant Info Qualifying Info Review Signature

### Applicant Information

[? Get Help](#)

Your employer or benefit plan administrator instructed you to fill out this application because:

I am a new employee  electing coverage for the first time

I am an existing employee  newly eligible for benefits  
 who had a family or status change  
 Change in waiting period

**Quick Tip**  
If you have any questions, please contact your employer or benefit plan administrator.  
Information updated on this form will not be sent to your employer or benefit plan administrator.

My application applies to the following coverage updates:

Who	Insurance Coverage Type
Me (Employee)	<input type="checkbox"/> Long Term Disability
	<input type="checkbox"/> Short Term Disability
	<input type="checkbox"/> Basic Life - Employee

NOTE: At any point during the application, you may click “Save for Later” to save the information entered to that point, log out, and return later to complete the application. If at any point you wish to end the process and permanently discard everything you entered, click “Delete Application”.

## My Family Information

If Dependent Life coverage is included in the application, enter information about the respective dependents, then select **Continue**.

### Evidence of Insurability (EOI)

Get Started  Applicant Info  Qualifying Info  Review  Signature  [Get Help](#)

## My Family Information

My Spouse/Domestic Partner's Information is:

First Name	Middle Initial
<input type="text"/>	<input type="text"/>
Last Name	Previous Last Name
<input type="text"/>	<input type="text"/>
Social Security Number	
<input type="text"/>	
Date of Birth (mm/dd/yyyy)	Height (ft. in.)
<input type="text"/>	<input type="text"/> ft. <input type="text"/> in.
Weight (lbs.)	Gender
<input type="text"/> lbs.	<input type="radio"/> Male <input type="radio"/> Female

# Qualifying Information

For each applicant, answer a series of Yes/No questions. If dependent children are included, they are grouped together. Answer “Yes” if it’s applicable to any child. When finished, select **Continue**.

**Evidence of Insurability (EOI)**

Get Started  Applicant Info  **Qualifying Info**  Review  Signature

**Qualifying Information** [? Get Help](#)

	You
1 During the past 3 years, have you been hospitalized, diagnosed, or treated by a medical professional for any disease, disorder, or condition other than annual exams and routine check-ups?	<input checked="" type="radio"/> Yes <input type="radio"/> No
2 Have you ever been diagnosed or treated by a medical professional or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	<input type="radio"/> Yes <input checked="" type="radio"/> No
3 During the past 3 years, have you ever been prescribed medication other than for a cold, cough, allergies, or for birth control?	<input type="radio"/> Yes <input checked="" type="radio"/> No
4 Are you currently pregnant?	<input type="radio"/> Yes <input checked="" type="radio"/> No
5 Have you ever had any application for life, disability, or health insurance declined, postponed, or not approved as applied for?	<input type="radio"/> Yes <input checked="" type="radio"/> No

[<Go Back](#) [Delete Application](#) [Save for Later](#) [Continue>](#)

## Medical Information

In some cases, you may be asked to enter information about existing medical conditions and/or prescribed medications.

- Select **+Add a Condition** to add additional medical conditions for an applicant or **Delete Condition** to remove a medical condition.
- Select **+Add a Medication** to add an additional medication for an applicant or **Delete Medication** to remove a medication.
- Select **condition library** in the Quick Tip box to access a sample list of medical conditions.

Once all medical conditions and prescribed medications are entered, select **Continue** to see the Review page.

**Evidence of Insurability (EOI)**

Get Started Applicant Info Qualifying Info **Medical Info** Review Signature

**Medical Information** [? Get Help](#)

**Quick Tip**  
Consult the [condition library](#) for examples of medical conditions.

**My Conditions:**

**Jenny | Condition1** [Delete Condition](#)

<b>Name of Condition</b> (diseases, disorders, illnesses, or conditions) e.g., heart attack	<b>Treatment Received</b> (describe details)	<b>Date of Onset</b> (mm/yyyy)	<b>Recovery Date, if Applicable</b> (mm/yyyy)
<b>Treating Health Professional</b> (full name)		<b>Medication</b> (name of medication prescribed)	<b>Date Medication Prescribed</b> (1st prescribed, mm/yyyy)

[+ Add a Condition](#) [+ Add a Medication](#)

[<Go Back](#) [Delete Application](#) [Save for Later](#) [Continue>](#)

Based on the medical conditions you entered in the Medical Information screen, you may need to provide more detail in the 'Additional Information' page. If so, answer the questions for each required applicant and medical condition.

# Review

Please review the information and responses on this page to ensure completeness and accuracy. If changes are necessary, select **Edit** to make necessary edits. You will be returned to the original screen to make the appropriate changes.

Once you are satisfied that all information is correct, select **Continue** to go to the 'Signature' page. Please be aware that once the application is submitted, changes are **not** allowed.

### Evidence of Insurability (EOI)

Get Started   Applicant Info   Qualifying Info   Medical Info   **Review**   Signature

[Get Help](#)

## Review

### Applicant Information [Edit](#)

Your employer or benefit plan administrator instructed you to fill out this application because: electing coverage for the first time

**My application applies to the following coverage updates:**

- Long Term Disability

**My Employee Information is:**

- Occupation Test
- Date of Hire 10/01/2003
- Annual Salary 52,000.00

**My Contact Information is:**

- Jenny Osburn

# Signature

Provide an electronic signature and select **Submit Application** to submit the EOI application.

## Evidence of Insurability (EOI)

Get Started   Applicant Info   Qualifying Info   Medical Info   Review   **Signature**

[Get Help](#)

### Signature

AUTHORIZATION TO OBTAIN INFORMATION - I AUTHORIZE any medical practitioner, facility, or related entity, insurer, Medical Information Bureau, Inc. (MIB), reporting agency, or employer to give any medical, financial, or personal information about me or my family members to Liberty Life Assurance Company of Boston (the Company), any third party acting on its behalf and its reinsurers. This authorization applies to all types of information, including but not limited to information regarding HIV infection, AIDS, mental health, and substance abuse. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I AM AWARE that the Company will use this information to determine if I am eligible for insurance or benefits. I am aware that the Company may give this information to its reinsurers, MIB, other persons or entities that perform services related to my application or claim, or as may be authorized or required by law. Information obtained with my authorization may be re-disclosed as permitted or required by law and may no longer be protected by federal privacy laws. I AGREE that this authorization shall be valid for 2 years from the date I sign it. I UNDERSTAND that I have the right to revoke this authorization at any time by written notification to the Company at the address listed on page 1 of this document. I agree that a copy will be as valid as this original. I MAY ASK for a copy of this form. I RECEIVED the [Notice of Information Practices](#) and the notices required by the Federal Fair Credit Reporting Act and MIB.

Any person who knowingly presents a false statement in an Evidence of Insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

I/(We) have read the Statement of Insurability and declare that all statements and answers given in this application are true and complete to the best of my (our) knowledge and belief. I/(We) understand that the statements and answers will be used by the Company to determine insurability.

I agree

Employee Signature (Typed)      Date Signed

Employee Name      Sep 14, 2016 02:10 PM ET

Country      State      City

United States      Select     

[<Go Back](#)      [Delete Application](#)      [Save for Later](#)      [Submit Application](#)



## Confirmation

Once your application has been submitted, the Confirmation screen will display an acknowledgement and next steps. Select **Download Application for Your Records** to open and save a copy of your application for your records.

Note: An email with the acknowledgement will also be sent.

### Confirmation

Thank You! You successfully submitted your application on 08/24/2018 at 01:34 PM ET.

#### YOUR NEXT STEPS

- Please take a moment to print or save a copy of your application for your records.

[View & Print Confirmation Report](#)

#### OUR NEXT STEPS

- We will review your application and request additional information if needed.
- Once we receive all necessary information, we will evaluate your application and notify you and your employer of our decision.

## Questions

If you have technical questions, please contact our Call Center at 1-800-431-2958. Approved insurance coverage will be administered in accordance with your employer's benefit plan.