

**EMPLOYEES RETIREMENT SYSTEM OF TEXAS**  
**Texas Employees Group Benefits Program (GBP)**  
**Evidence of Insurability (EOI) Application**  
**Active/Retired Employees**

Evidence of Insurability (EOI) may be required to 1) enroll in, 2) add dependents to, or 3) increase some GBP insurance coverages.

Evidence of Insurability means that you must provide, at no expense to Fort Dearborn Life Insurance Company (FDL), evidence of good health. To be considered for coverage, this EOI Application (Form No. ERS-EOI-App-05, Stock No. 8710.558-505) must be completed in its entirety, signed, dated, and returned to FDL. You and any dependent applying for coverage are required to answer the medical questions (which may include providing medical records and a physical exam). The information you provide on this EOI Application and any additional information requested and received is subject to review and approval by FDL Medical Underwriting. **Coverage will either be approved or denied based on the information provided.**

**GENERAL INSTRUCTIONS**

**Important:** Write your agency name, agency number and region number in the box in the upper right-hand corner of this Application. If you need assistance in completing this section and **you are an active employee**, contact your benefits coordinator or refer to the agency list found with the EOI form at [www.ers.state.tx.us/insurance/forms](http://www.ers.state.tx.us/insurance/forms). (Click on "Use the agency list in alpha order or in numerical order" under the Form Description column.) **If you are a retiree**, write ERS under Agency Name and write 0327 under Agency Number. FDL Medical Underwriting uses this information to communicate underwriting decisions of approval, denial and file closure to Benefits Coordinators and ERS.

**SECTION A: EMPLOYEE/RETIREE DATA**

Complete this section and specify your complete mailing address, ZIP Code, and Eligibility County.

**Important:** To prevent processing delays, provide your complete Social Security number, ERS OnLine employee identification number and current height/weight.

**SECTION B: EMPLOYEE/RETIREE COVERAGE ADDITIONS AND CHANGES**

**Only** check the box(es) for new coverage(s) you are applying for. **DO NOT** check the box(es) for coverage(s) you already have.

**SECTION C: DEPENDENT COVERAGE**

Complete this section if you are applying for HealthSelect and/or Dependent Life coverage for any of your dependent(s). Write the full name of any dependent applying for coverage and check the box below the selected coverage. **Important:** To prevent processing delays, provide the complete Social Security number and current height/weight for any person applying for coverage.

**SECTION D: HEALTH INFORMATION**

**Important:** You must answer all questions for any person applying for coverage. If you answer "Yes" to any question, please use the space in Section D on page 3 to provide details. Failure to provide details will cause a delay in the review of your Application.

**SECTION E: AGREEMENTS AND AUTHORIZATION**

Please read the Agreements and Authorization before signing this Application. Your signature is required and must be legible. The signature of your spouse is required (if requesting insurance) as well as the signature of any dependent child(ren) age 18 and older (if requesting insurance). This Application must be dated with the current month, day and year.

Provide work and home phone numbers and include extension numbers, if applicable. You should keep a copy of the completed Application for your own records.

Return this completed Application (pages 1-4) to:

Fort Dearborn Life Insurance Company  
Administrative Offices, Attn: Medical Underwriting Dept.  
P.O. Box 655403  
Dallas, Texas 75265-5403

For underwriting questions or the status of an EOI application, please call:  
1-800-451-0271 (Option 1) Monday – Friday 8:00 a.m. – 4:30 p.m.



**BlueCross BlueShield  
of Texas**



**FORT DEARBORN LIFE  
Insurance Company**

**Texas Employees Group Benefits Program  
Evidence of Insurability Application  
Active/Retired Employees**

**REMEMBER: You must complete this application in its entirety to be considered for coverage. Return this application to:**  
**Fort Dearborn Life Insurance Company**  
**Administrative Offices, Attn: Medical Underwriting Dept.**  
**P.O. Box 655403**  
**Dallas, Texas 75265-5403**

<b>To be completed by the Employee/Retiree. If applying for retiree coverage, please indicate ERS – 0327.</b>	
Agency Name	Agency No.
District / Region No.	

**You must complete each page in full, and the application must be signed and dated on Page 4 to be considered. Please complete this application in black or blue ink.** This form cannot be considered unless received by FDL within 30 days of completion. Insurance that requires satisfactory evidence of good health will not be effective for an applicant unless, and until, FDL accepts this evidence as satisfactory. The information on this form will be considered current for no longer than 90 days.

**Section A: Employee/Retiree Data (This section must be filled out completely for application to be considered.)**

Social Security No. - -	<input type="checkbox"/> Employee	<input type="checkbox"/> Retiree	<input type="checkbox"/> Return-to-Work Retiree	MI	Date of Birth Mo. Day Year / /	Height Ft. / In.	Weight Lbs.
ERS OnLine Empl ID:	Name: Last	First	MI				
Home Mailing Address - Street				City	Eligibility County	State	Zip
<b>Complete only One Line:</b> Employee Hire Date: ____/____/____ Retiree Retirement Date: ____/____/____ Retiree Return-to-Work Date: ____/____/____				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Do you currently have medical coverage under the Group Benefits Program provided by the State of Texas? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Section B: Employee/Retiree Coverage Additions and Changes (Please do not reapply for existing coverage.)**

<b>HealthSelect of Texas</b> (Administered by Blue Cross and Blue Shield of Texas*)	<b>Optional Coverages</b> (Administered by Fort Dearborn Life Insurance Company)		
<b>Medical Coverage</b>	<b>Life Insurance (Employees only)</b>	<b>Life Insurance (Retirees only)</b>	<b>Disability Income Insurance (Employees only)</b>
<input type="checkbox"/> Add or Change to HealthSelect <i>(Do not check if you already have HealthSelect coverage.)</i>	<input type="checkbox"/> Term Life – Election I <input type="checkbox"/> Term Life – Election II <input type="checkbox"/> Term Life – Election III <input type="checkbox"/> Term Life – Election IV	<input type="checkbox"/> 10,000 Optional Term Life	<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability

**Section C: Dependent Coverage – List all dependents applying for HealthSelect and/or Dependent Life and check the appropriate box(es). If additional space is needed, include a separate sheet and please remember to sign and date it.**

Relationship to Employee/Retiree	Health Select	Dependent Life	Name: Last	First	MI	Social Security No.	Date of Birth Mo./Day/Year	Height Ft. / In.	Weight Lbs.
1. Spouse Marriage Date ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	/	
2. <input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	/	
3. <input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	/	
4. <input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	/	
5. <input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	/	
6. <input type="checkbox"/> Other Specify _____	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	/	

Employee/Retiree Name \_\_\_\_\_

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Section D: Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)**

Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "Yes" answers must be provided below. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.

	Employee/ Retiree		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Has any person applying for coverage been seen, treated, advised or received services from any health provider <u>in the last 12 months</u> , including routine physicals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>2. Has any person for whom coverage is requested EVER HAD symptoms, been diagnosed with, and/or received treatment by/from a member of the health profession for any of the conditions listed in the questions below?</b>						
a. High blood pressure, heart attack, chest pain, shortness of breath, irregular heartbeat, murmur, coronary artery disease, heart surgery (catheterization/angioplasty/bypass, etc.), or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Enlarged glands, thyroid disorder, diabetes, abnormal glucose level, hepatitis, cirrhosis, abnormal liver studies, hernia, ulcer, colitis or any other disease or disorder of the liver, endocrine, or digestive system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia or any other mental/nervous/behavioral disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Asthma, emphysema, tuberculosis, pneumonia, COPD, sleep apnea, or any other disease or disorder of the throat, lungs, or respiratory tract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Prostate, uterus/tubes/ovaries, endometriosis, cystitis, kidney stone, renal failure, sexually transmitted diseases, any disorder of the kidneys/bladder/urinary tract, breast lumps/changes/biopsies, abnormal test results or any other male/female disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Cysts, moles, warts, polyps, cancer or tumor (indicate location and if benign/malignant)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, or any other disease or disorder of the nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Arthritis, gout, rheumatism, neck or back strain/sprain/injury, deformity, loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has any person applying for coverage been diagnosed with or received treatment for an immune system disorder, including AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does any person applying for coverage currently take medication (prescription or otherwise), been prescribed medication, or has any person done so <u>in the last 6 months</u> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. <u>Within the last 2 years</u> , has any person applying for coverage had a physical disability, surgery, or been confined to a hospital, skilled nursing or rehabilitation facility; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, MRI, CAT Scans, PET or CT Scans, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment; and/or been advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed, not mentioned in questions 1 through 4?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Is any person applying for coverage <u>currently</u> pregnant? If "Yes", indicate anticipated delivery date _____. <b>Provide details of any current/prior complications on Page 3.</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has any person applying for coverage <i>EVER HAD</i> symptoms, been diagnosed with, and/or received treatment from a member of the health profession for <b>ANY HEALTH CONDITION</b> other than those conditions listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Employee/Retiree Name \_\_\_\_\_

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

It is the responsibility of the applicant/patient to obtain the requested medical information. The Attending Physician's Statement (APS) form includes a Patient's Authorization to release medical information. The patient must sign and date the authorization form(s) and send to the doctor/facility listed on the form(s). Any fee charged for completion of the APS form(s) and release of medical records is the responsibility of the applicant/patient.

**Section E: AGREEMENTS AND AUTHORIZATION – Please read carefully before signing.**

I, the undersigned applicant(s), have read and agree that the above statements and answers are furnished in support of my Application and are complete, true and correctly recorded to the best of my knowledge and belief. I agree that they shall be relied upon as the basis of the issuance of insurance for me. Except where specifically provided in the applicable group policies, under which coverage is provided, Blue Cross and Blue Shield of Texas (BCBSTX) and Fort Dearborn Life Insurance Company (FDL), which are herein collectively called the Company, and/or Employees Retirement System of Texas (ERS) shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to approval of my request for insurance.

I understand that coverage will be approved or denied only for those individuals listed on this Application. I also understand that incorrect, incomplete, or untrue or misleading answers on this Application may result in rescission of my coverage or that of my dependents, or denial of any claims subject to the terms of the contract, and may be cause for permanent expulsion from the Texas Employees Group Benefits Program ("GBP") or other sanctions according to the terms of Chapter 1551, Texas Insurance Code.

I understand and agree that:

This authorization is voluntary but that my signature is required in order for the Company to consider this Application for me and each of my dependents and to make a determination on whether to accept and issue the coverage(s) applied for herein;

- If I refuse to sign this authorization, the Company has the right to deny my request for coverage or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the Federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire the later of 24 months from the date it is signed or at the end of any appeal process concerning this Application;
- All correspondence regarding coverage for those individuals listed on this Application will be sent to the Employee/Retiree;
- The information I have provided in this Application is true, correct, and complete to the best of my knowledge.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from the Company.

To determine my eligibility for the coverage(s) applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, HMO, MCO, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's underwriting department or its authorized representative(s) and ERS any information relating to me or my dependents concerning advice, care, or treatment, including any claims processed by BCBSTX and/or FDL, and prescriptions for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

**WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance coverage or statement of claim containing any materially false information, or conceals or omits for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. A person who commits a fraudulent insurance act or who induces the extension of coverage or payment of a claim by a materially negligent or intentional misrepresentation of fact may be subject to sanctions or expulsion from the GBP.

X \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Signature of Employee/Retiree Date Daytime Phone Evening Phone

X \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Signature of Spouse (if requesting insurance) Date Daytime Phone Evening Phone

X \_\_\_\_\_ \_\_\_\_\_  
Signature of Dependent Child – age 18 and older (if requesting insurance) Date

X \_\_\_\_\_ \_\_\_\_\_  
Signature of Dependent Child – age 18 and older (if requesting insurance) Date

X \_\_\_\_\_ \_\_\_\_\_  
Signature of Dependent Child – age 18 and older (if requesting insurance) Date

**Remember:** You must complete this application in its entirety to be considered for coverage. Return this application to:  
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75265-5403

*\*A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association*