



Evidence of Insurability Procedure Guide

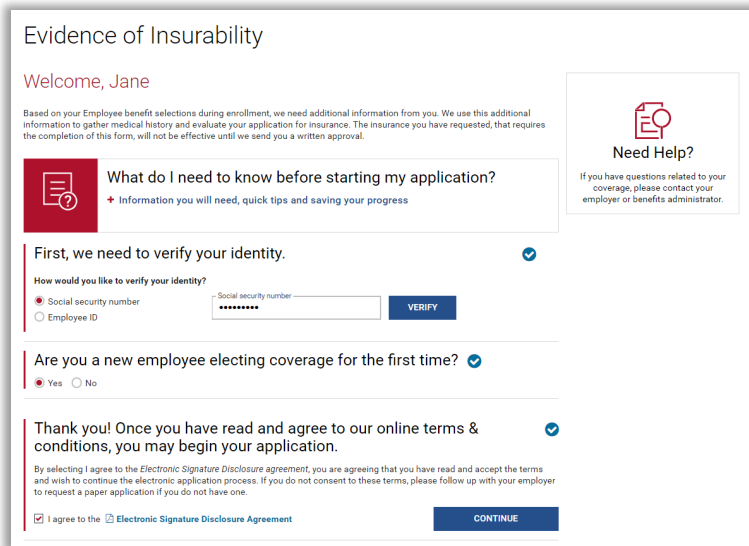
2021 Version 6.0

Electronic EOI Submission

Electronic EOI is done through a www.MyLincolnPortal.com link provided to the group and should be used as a standard in approved states.

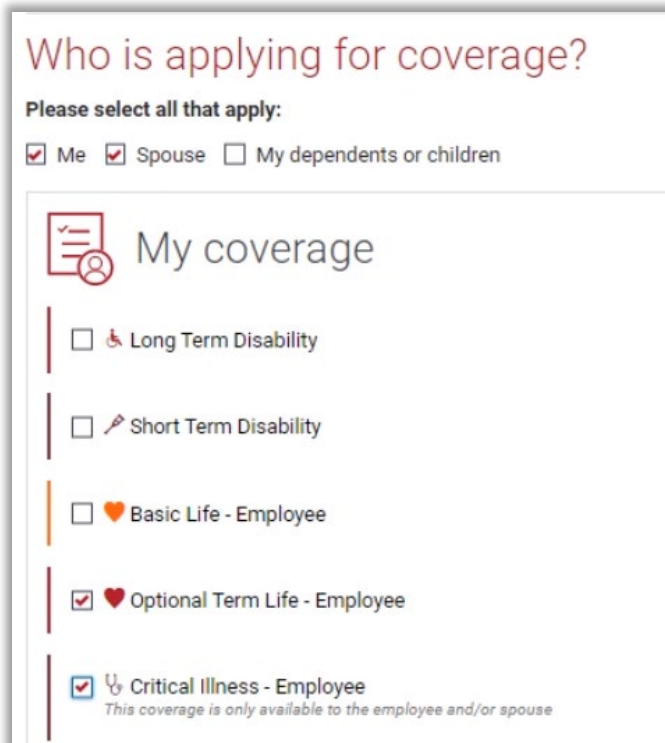
When a member receives the link, they will register using their name and Company Code that will be provided to the group. The company code is GRANDVALLE. Below are the steps to complete EOI.

Step 1: The member will begin with some basic information about why they are completing EOI.



The screenshot shows the 'Evidence of Insurability' web form. At the top, it says 'Welcome, Jane'. Below this, a message states: 'Based on your Employee benefit selections during enrollment, we need additional information from you. We use this additional information to gather medical history and evaluate your application for insurance. The insurance you have requested, that requires the completion of this form, will not be effective until we send you a written approval.' To the right of this message is a 'Need Help?' section with a question mark icon and text: 'If you have questions related to your coverage, please contact your employer or benefits administrator.' Below the message is a section titled 'What do I need to know before starting my application?' with a plus icon and text: '+ Information you will need, quick tips and saving your progress'. The main form area has a heading 'First, we need to verify your identity.' with a blue checkmark icon. Below this is a section 'How would you like to verify your identity?' with two radio buttons: 'Social security number' (selected) and 'Employee ID'. To the right of the 'Social security number' radio button is a text input field containing '*****' and a 'VERIFY' button. Below this is a section 'Are you a new employee electing coverage for the first time?' with a blue checkmark icon and two radio buttons: 'Yes' (selected) and 'No'. At the bottom, there is a 'Thank you!' message: 'Thank you! Once you have read and agree to our online terms & conditions, you may begin your application.' with a blue checkmark icon. Below this is a small text block: 'By selecting I agree to the Electronic Signature Disclosure agreement, you are agreeing that you have read and accept the terms and wish to continue the electronic application process. If you do not consent to these terms, please follow up with your employer to request a paper application if you do not have one.' Below this text block are two checkboxes: 'I agree to the' (checked) and 'Electronic Signature Disclosure Agreement' (checked). To the right of these checkboxes is a 'CONTINUE' button.

Step 2: The member will be asked to complete **Applicant Coverage**.




The screenshot shows the 'Who is applying for coverage?' web form. At the top, it says 'Who is applying for coverage?'. Below this is a section 'Please select all that apply:' with three checkboxes: 'Me' (checked), 'Spouse' (checked), and 'My dependents or children' (unchecked). Below this is a section titled 'My coverage' with a checkmark icon. Below this section are five checkboxes: 'Long Term Disability' (unchecked), 'Short Term Disability' (unchecked), 'Basic Life - Employee' (unchecked), 'Optional Term Life - Employee' (checked), and 'Critical Illness - Employee' (checked). Below the 'Critical Illness - Employee' checkbox is a note: 'This coverage is only available to the employee and/or spouse'.

Step 3: The member will then be asked to complete **Applicant Information**.

Evidence of Insurability

1 Applicant coverage
2 Applicant information
3 Qualifying medical questions
4 Review and submit application

Please provide information for all applicants applying for coverage


My information
Edit

EMPLOYMENT INFORMATION

As an employee, are you actively at work?

☐ Yes ☐ No

Are you a full-time or part-time employee?

☐ Full-time ☐ Part-time

What is your current annual salary?

Annual salary

Please provide the following:

Employee occupation Employee ID

Date of hire Date of rehire (Optional)

PERSONAL INFORMATION

First name Last name

Jane Employee

Middle initial

Social security number

Date of birth Sex at birth Birth state

Marital status:

☐ Single ☐ Married ☐ Domestic partnership ☐ Civil Union

Height: Weight:

Feet Inches lbs.

CONTACT INFORMATION

Select phone type Phone number Email

elkin425@jwlying.com

Preferred method of communication

Email

Residential address

Residential address 1 Residential address 2 (Optional)

Residential city Select State

Postal code Country

United States

☐ Use my residential address

Mailing address

Mailing address 1 Mailing address 2 (Optional)

Mailing city Select State

Postal code Country

United States

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Delete application
Save for later
CONTINUE

Step 4: The member will then be asked to complete **Qualifying Medical Questions**.

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Applicant coverage

2

Applicant information

3

Qualifying medical questions

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Review and submit application

Evidence of Insurability

Qualifying medical questions

The following health questions must be answered fully and truthfully to the best of your knowledge and belief for each applicant.

Agreement of terms

	MYSELF
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.	<input type="radio"/> Yes <input type="radio"/> No

Tobacco or nicotine products

	MYSELF
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)?	<input type="radio"/> Yes <input type="radio"/> No

Medical information

Within the past 5 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with, or treated by a licensed member of the medical profession for any of the following diseases, illnesses, or conditions:

DISEASES, ILLNESSES, OR CONDITIONS	MYSELF
Heart disease, heart condition, or symptoms related to the heart, vascular or circulatory disease, hypertension/high blood pressure, history of stroke, ministroke, or Transient Ischemic Attack (TIA)?	<input type="radio"/> Yes <input type="radio"/> No
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?	<input type="radio"/> Yes <input type="radio"/> No
Chronic neurological disease or disease of the brain or nervous system, disease or disorder of the blood or immune system, mental or cognitive disorder, alcohol or drug abuse, depression or anxiety?	<input type="radio"/> Yes <input type="radio"/> No
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 for more than 7 consecutive days due to any disease, illness, or condition?	<input type="radio"/> Yes <input type="radio"/> No
Within the past 5 years, to the best of your knowledge and belief, has anyone applying for insurance tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?	<input type="radio"/> Yes <input type="radio"/> No

Critical illness information

You must complete this section of questions if applying for Critical Illness insurance. You must answer yes or no for each question per applicant to avoid a processing delay.

SPECIALTY ILLNESSES, OR CONDITIONS	MYSELF
1. Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance: a. Been diagnosed or treated by a licensed member of the medical profession for Systemic Lupus, Type I or II Diabetes's, or sarcoidosis? b. Tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?	<input type="radio"/> Yes <input type="radio"/> No
Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for Pacemaker, any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?	<input type="radio"/> Yes <input type="radio"/> No
To the best of your knowledge and belief, is anyone applying for insurance currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	<input type="radio"/> Yes <input type="radio"/> No
Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for internal cancer, lymphoma, leukemia or melanoma?	<input type="radio"/> Yes <input type="radio"/> No
Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor?	<input type="radio"/> Yes <input type="radio"/> No
Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for glaucoma or retinitis pigmentosa?	<input type="radio"/> Yes <input type="radio"/> No

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Step 5: The member will need to Review Application and Submit.

Evidence of Insurability

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Applicant coverage
Applicant information
Qualifying medical questions
Review and submit application

Review your application

You were instructed to fill out this application today because of Please make sure all of the following coverage selections for each application is correct before continuing.

If you need to make updates to any applicant information, you will be directed back to the corresponding section of this application.



Jane Employee

COVERAGE SELECTION(S)

[Edit](#)

- ☒ Voluntary Life - Employee
- ☐ Critical Illness - Employee

EMPLOYMENT INFORMATION

[Edit](#)

Actively at work	Full-time/part-time	Current annual salary
Yes	Full-time	\$150,000

Employee occupation	Employee ID	Date of hire
asdf	asdf	01/01/1980

Date of rehire

PERSONAL INFORMATION

[Edit](#)

First name	Middle initial	Last name
Jane		Employee

Social security number	Date of birth	Sex at birth
****6789	01/01/1960	F

Birth state	Height	Weight
NE	5' 5"	150 lbs

Marital status:
Single

CONTACT INFORMATION

[Edit](#)

Phone type	Phone number	Email
Work	(402) 123-4567	elkin425@jwlying.com

Preferred method of communication
Email

Residential address:
[Use my residential address](#)

Residential address 1	Residential address 2
1234 Main St.	

Country	State	Mailing city	Zip code
United States	NE	Omaha	68114

Qualifying medical questions

[Edit](#)

Agreement of terms

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.

Yes

Tobacco or nicotine products

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)?

No

Medical information

Within the past 5 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with, or treated by a licensed member of the medical profession for any of the following diseases, illnesses, or conditions:

Heart disease, heart condition, or symptoms related to the heart, vascular or circulatory disease, hypertension/high blood pressure, history of stroke, ministroke, or Transient Ischemic Attack (TIA)?

No

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?

No

Chronic neurological disease or disease of the brain or nervous system, disease or disorder of the blood or immune system, mental or cognitive disorder, alcohol or drug abuse, depression or anxiety?

No

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 for more than 7 consecutive days due to any disease, illness, or condition?

No

Within the past 5 years, to the best of your knowledge and belief, has anyone applying for insurance tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

No

Critical illness information

You must complete this section of questions if applying for Critical Illness Insurance. You must answer yes or no for each question per applicant to avoid a processing delay.

Specialty illnesses, or conditions

1. Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance: a. Been diagnosed or treated by a licensed member of the medical profession for Systemic Lupus, Type I or II Diabetes's, or sarcoidosis? b. Tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

No

Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for Pacemaker, any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?

No

To the best of your knowledge and belief, is anyone applying for insurance currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?

No

Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for internal cancer, lymphoma, leukemia or melanoma?

No

Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor?

No

Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for glaucoma or retinitis pigmentosa?

No

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[CONTINUE](#)

Step 5: The last step is for the member to complete the **Electronic Agreement and Signature**.

Evidence of Insurability

① *Applicant coverage*
② *Applicant information*
③ *Qualifying medical questions*
④ *Review and submit application*

Electronic agreement and signature

Please review the authorization disclosure and provide your consent prior to submitting your application.

Fraud Warning/State Disclosure(s)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM, OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Acknowledgments

- I request the insurance for which I am (or may become) or my Spouse is (or may become) or my Child(ren) are (or may become) eligible under group policies issued by the Company;
- I authorize any required deductions from my pay;
- 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;
- 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

☐ I acknowledge that I have reviewed the authorization disclosure above and that I have received the

[Notice of Information Practices](#)

ESIGNATURE(S)

If you consent to the terms outlined above for your coverage application, type your full name in the box below and select submit.

Jane Employee

Date: 02/12/2021

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Delete application
Save for later
SUBMIT

Step 6: Once completed, the member will receive a confirmation number that they can use to check the status of their EOI submission.

Evidence of insurability confirmation

✓ You have successfully submitted your information.

Your evidence of insurability event number is #62327

Thank You! You successfully submitted your application on 2/12/2021 at 12:30:40 PM.

[View & Print My Application](#)

Your next steps

- Please take a moment to print or save a copy of your application for your records.
- To view your Evidence of Insurability status log into My Lincoln Portal and click on View Status button. Your status will be available for viewing 24 hours after your submission.

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.

If the requested insurance coverage is approved, it will be administered in accordance with your employer's benefit plan.

Electronic EOI


For members who completed their EOI information through www.MyLincolnPortal.com, the approval or denial decision will be posted automatically, if the information was sufficient to make a decision.

Note: Due to potential delays with information updating, please quote 24 hours for decisions to be posted.

If the EOI request is approved, the approval letter will state this fact but will not detail the amount of coverage for which the member was approved. Self-billed groups will monitor how much coverage the member has before and after the EOI request. The EOI approval just signifies the member is allowed to increase their coverage, not the specific amount they are allowed to have.

Sample Decision Letters

Approved

 You're In Charge®	Medical Underwriting Lincoln Financial Group P.O. Box 2870 Omaha, NE 68103-2870
April 6, 2020	
FIRST NAME LAST NAME 10 Maine St. Durham, NH 03824 USA	
RE: Coverage with Customer Demo Application ID: 36314 Basic Life - Employee	
The above named employee has been approved for Group Coverage effective 05/01/2020.	
Your eligibility for this coverage is subject to the provisions of your employer's plan and any state limitations on coverage amounts.	
If you have any questions regarding this notice including current coverage and coverage amounts, please contact your Benefits Administrator.	
Sincerely, Group Underwriting Services	

Declined

April 6, 2020

FIRST NAME LAST NAME

10 Maine St.

Durham, NH 03824 USA

RE: Group plan with Customer Demo

Coverage(s) Requested:

Short Term Disability

Application ID: 36314

After carefully considering the recent application for the above Group Coverage, we regret that we cannot issue the coverage requested. Our action was based on information provided on the Evidence of Insurability application.

Your request for coverage has been denied due to your elevated Body Mass Index (BMI). Based on our underwriting guidelines for group coverage we would reconsider an application for coverage if a BMI of 33.9 or less was maintained for six months or more. *For more information on healthy BMI visit National Heart, Lung, and Blood Institute at www.nhlbi.nih.gov/health.*

If there are any group benefits in force, they will not be affected by this decision.

Due to the confidential nature of your medical history, it is our policy to not discuss the details of our decision over the phone. We encourage you to submit any and all questions about our decision in writing per the instructions below.

The written request for review must be sent within 90 days of the date of this letter and state the reasons you feel the application should not have been denied. In the request for review, please include your Application ID 36314 and the following documentation: additional medical documentation such as treatment notes and test results that were not previously submitted for review from treating providers, that supports the appeal, as well as any additional information you feel will support the appeal. You may request to review pertinent documents upon which the denial of the requested coverage was based. Under normal circumstances, you will be notified of the final decision within 30 business days of the date that the appeal is received.

Please send any appeal documentation to:

Medical Underwriting
Lincoln Financial Group
P.O. Box 2870