Lincoln Financial Group®

Evidence of Insurability

Procedure Guide

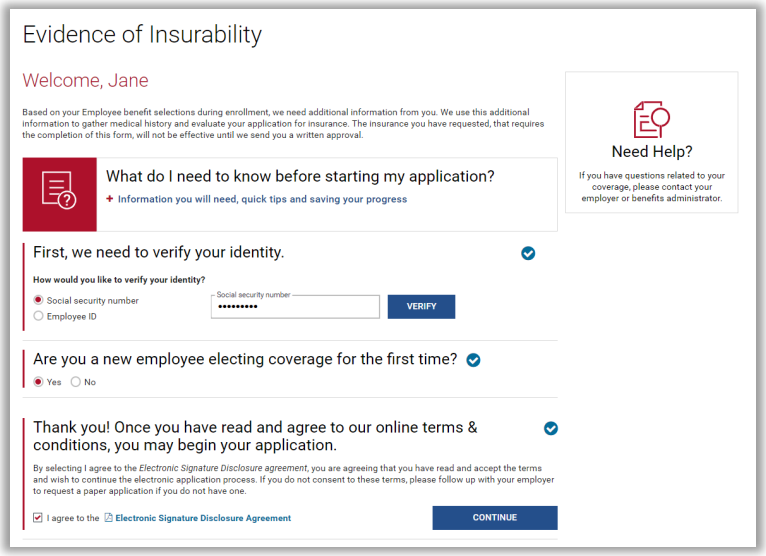
2021 Version 6.0

Electronic EOI Submission

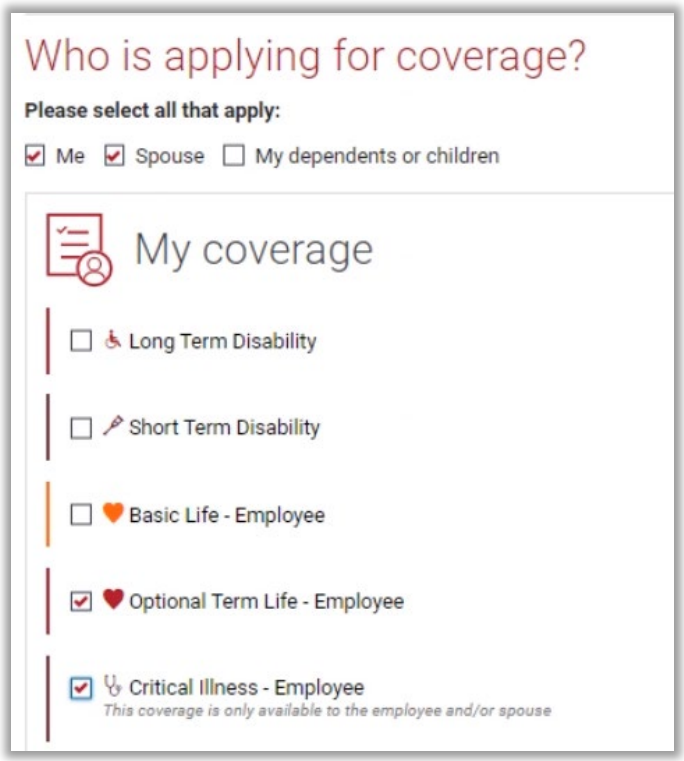
Electronic EOI is done through a www.MyLincolnPortal.com link provided to the group and should be used as a standard in approved states.

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.

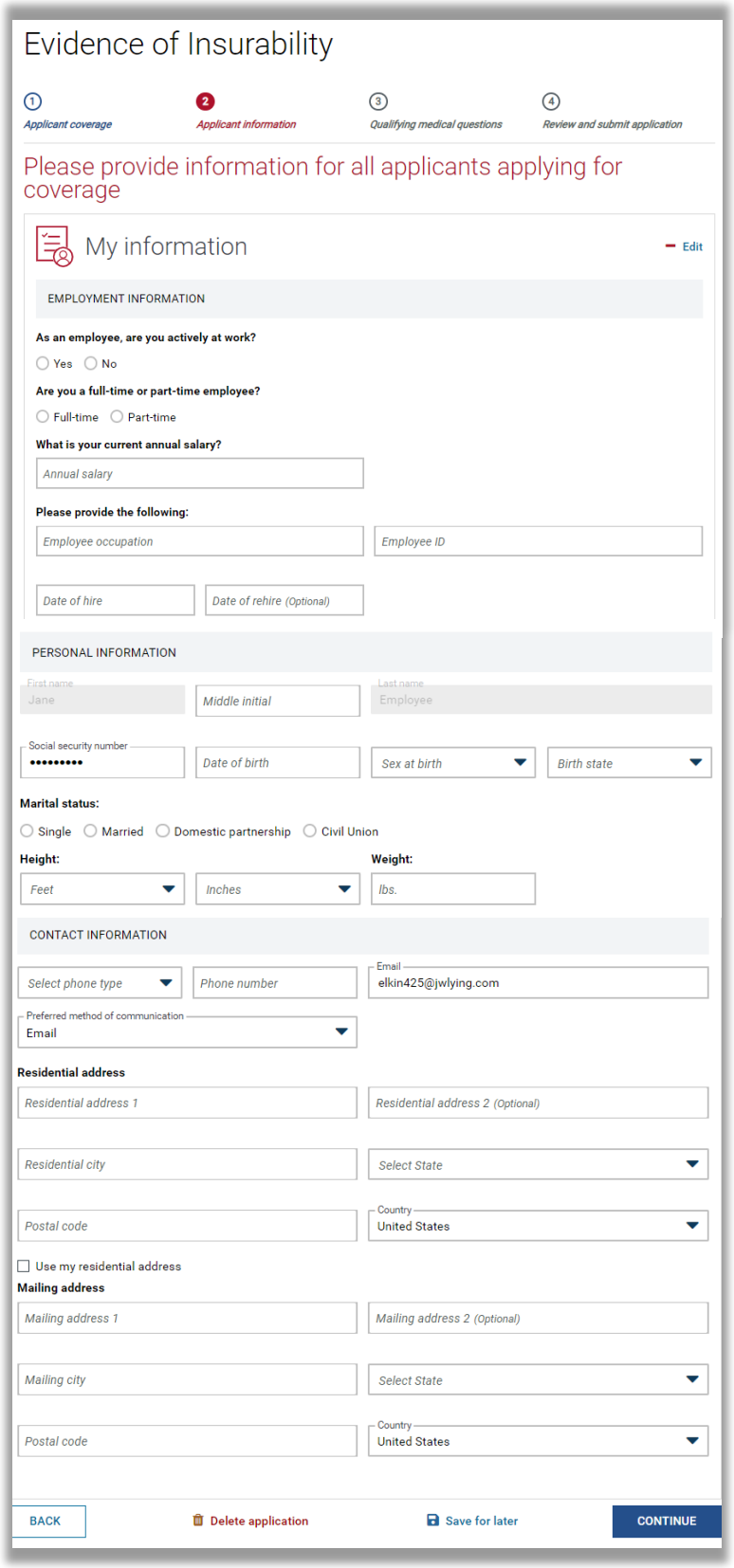
Step 1: The member will begin with some basic information about why they are completing EOI.



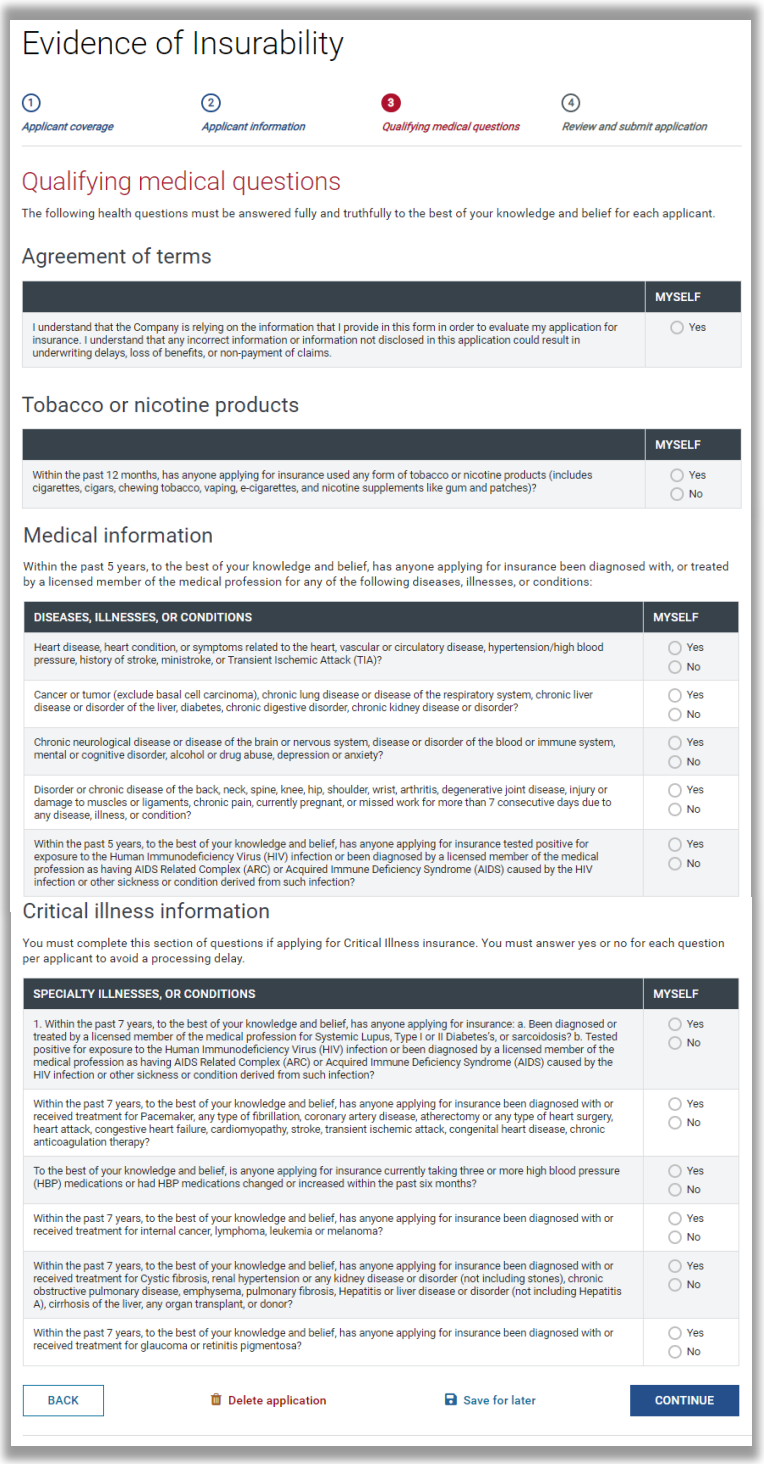
Step 2: The member will be asked to complete **Applicant Coverage**.



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



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



Evidence of Insurability

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

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.	○ Yes

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)?	○ Yes ○ 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)?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ No

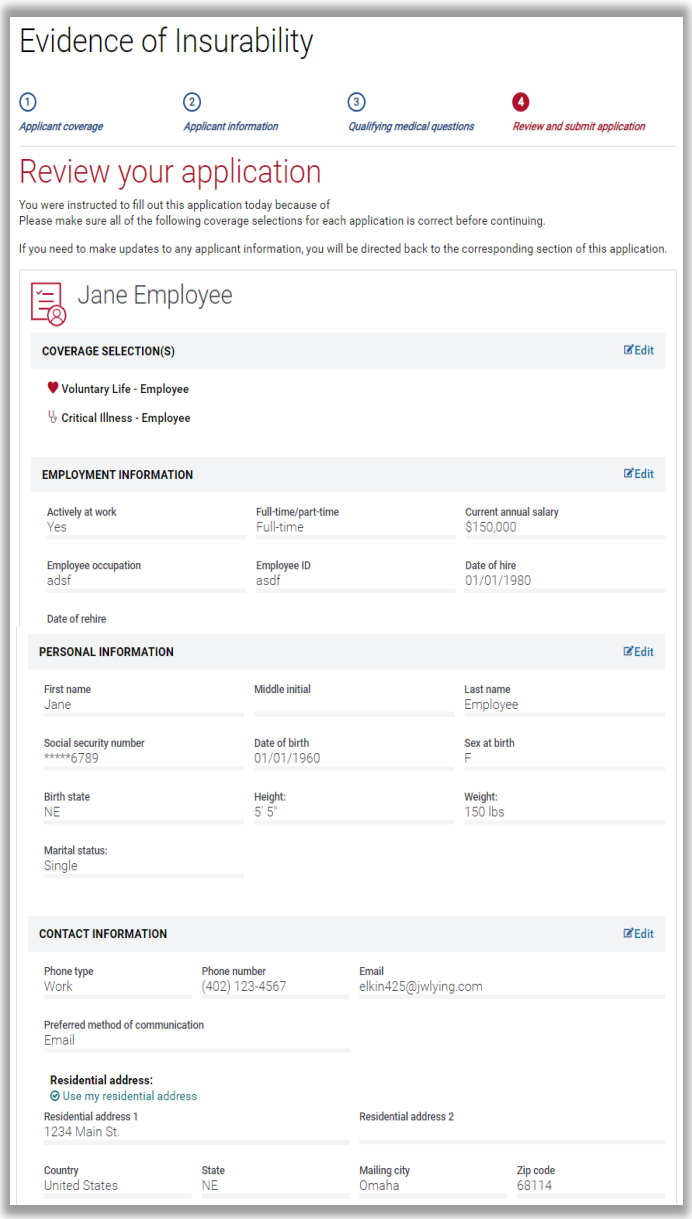
Critical illness information

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?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ No

BACK — Delete application — Save for later — CONTINUE

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



Evidence of Insurability

1 Applicant coverage | 2 Applicant information | 3 Qualifying medical questions | 4 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
adsf	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

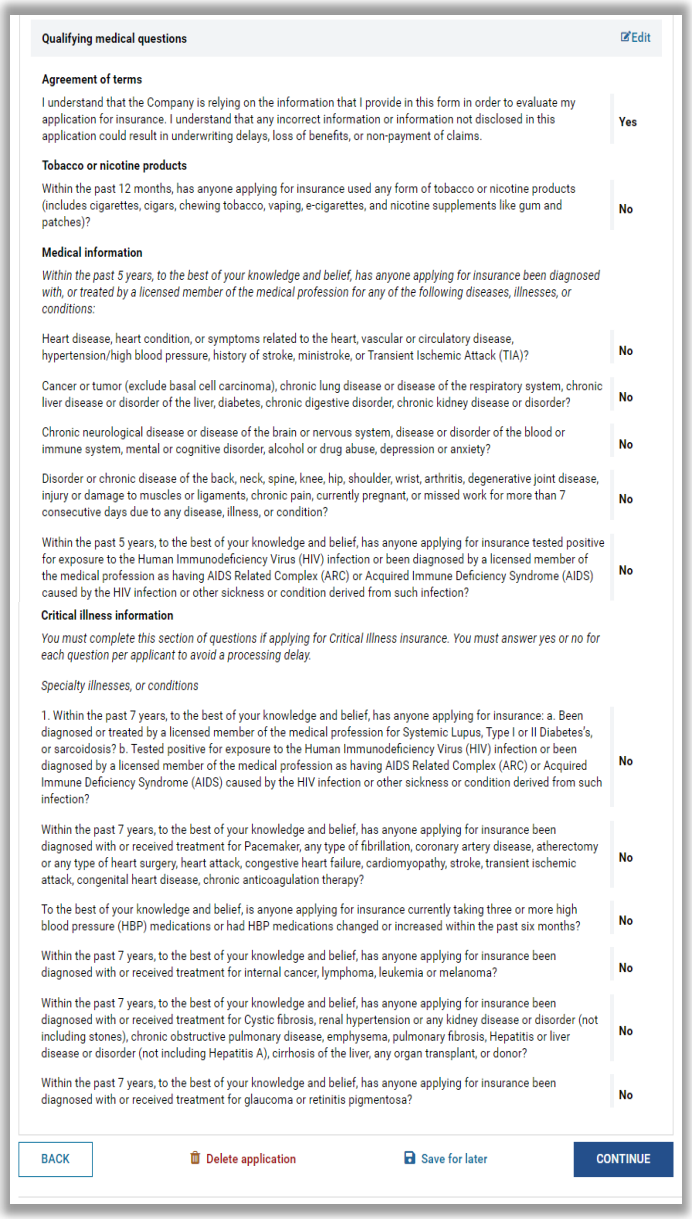
Phone type	Phone number	Email
Work	(402) 123-4567	elkin425@jwlying.com

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

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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**

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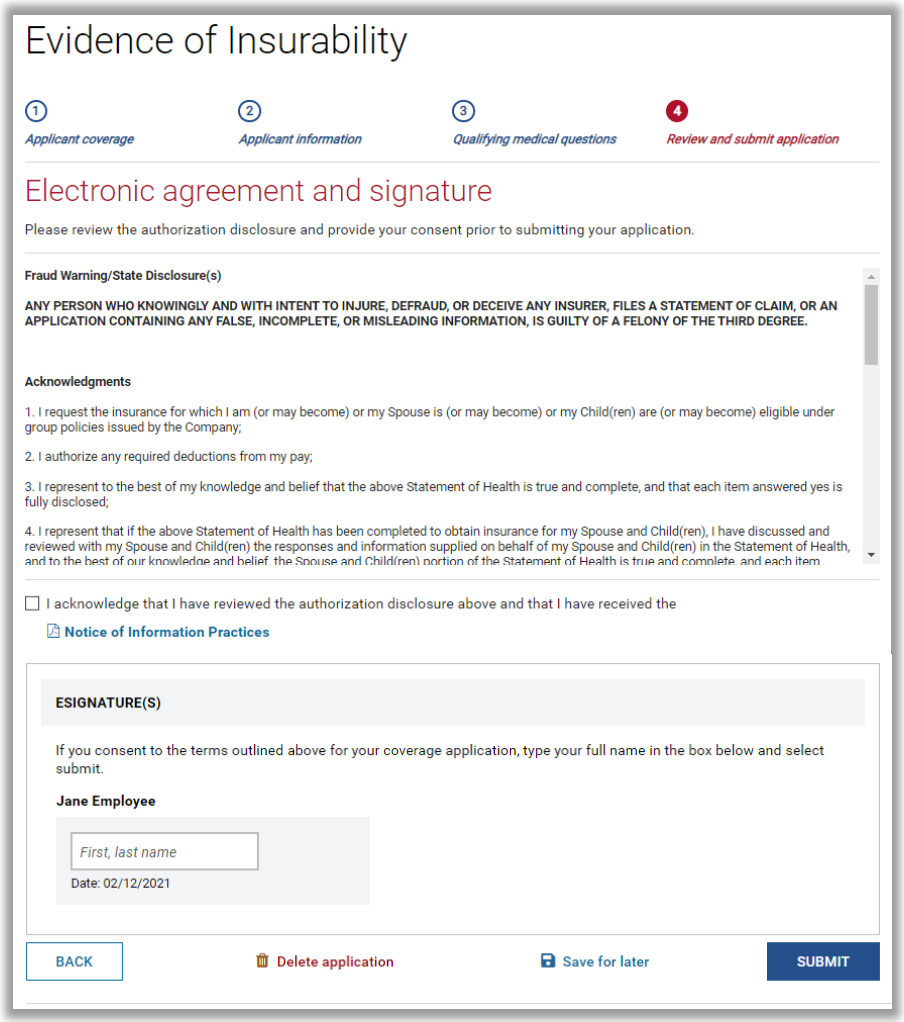
Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor? **No**

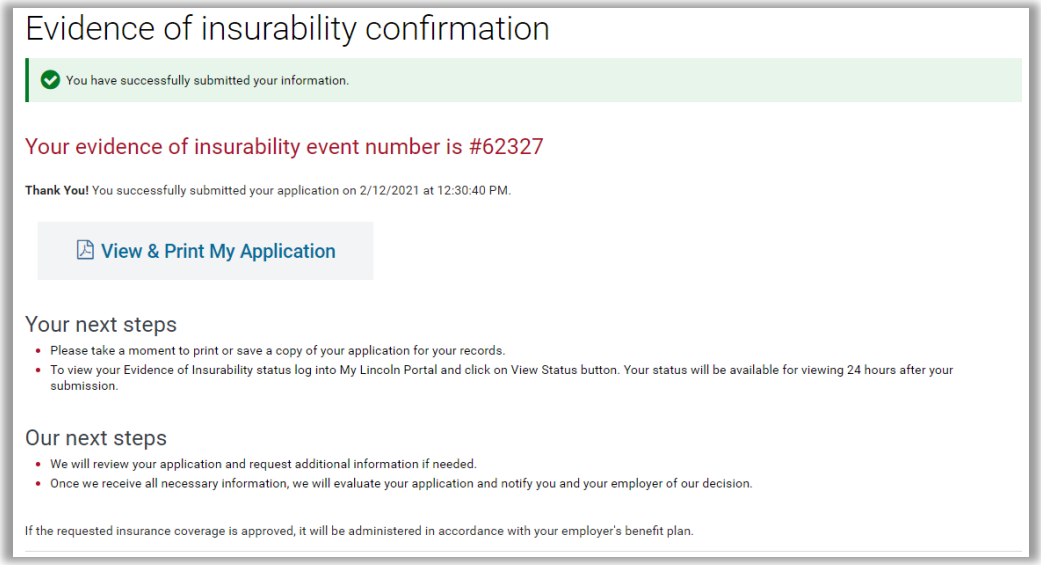
Within the past 7 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or received treatment for glaucoma or retinitis pigmentosa? **No**

BACK | Delete application | Save for later | CONTINUE

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



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



Electronic EOI

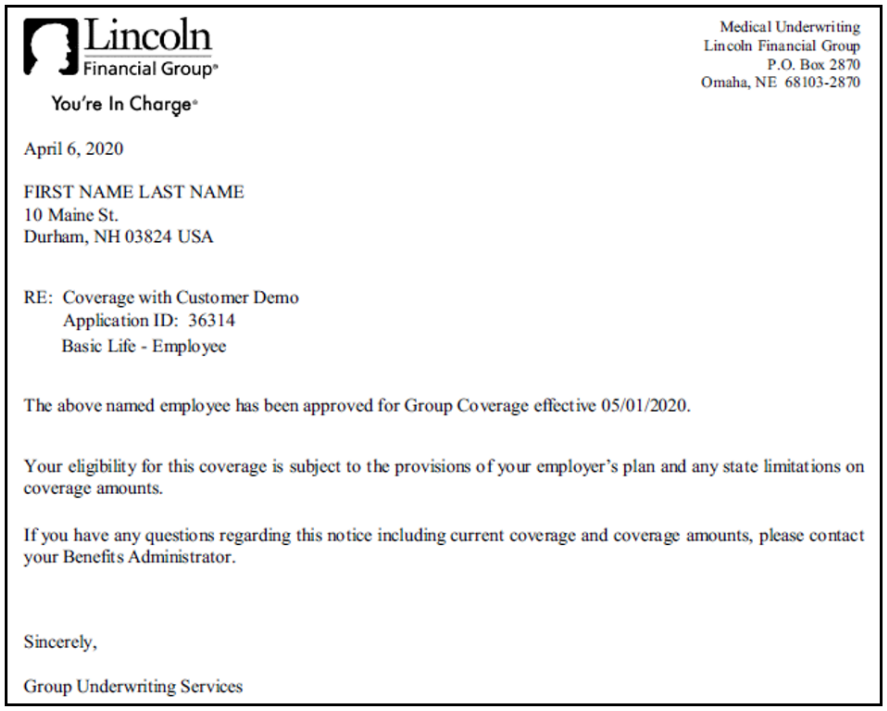
For members who completed their EOI information through www.MyLincolnPortal.com, the approval or denial decision will be posted automatically, if the information was sufficient to make a decision.

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



Lincoln Financial Group®

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