



RTMUS Evidence of Insurability Procedure Guide

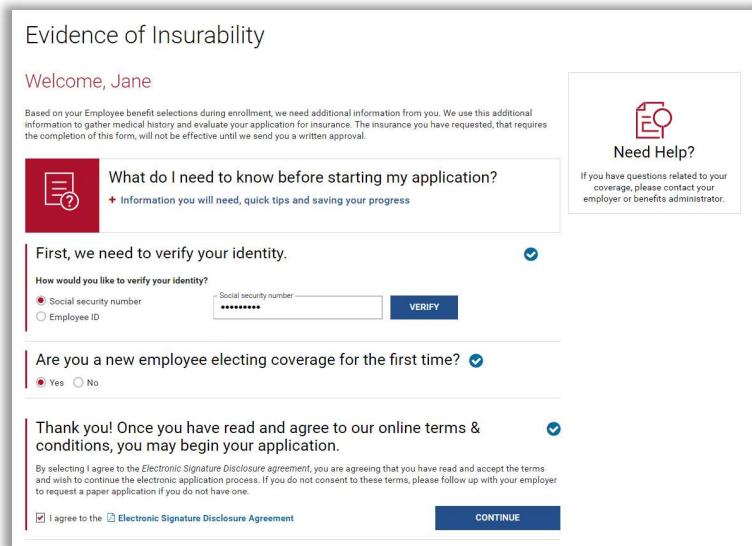
2021 Version 6.0

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.

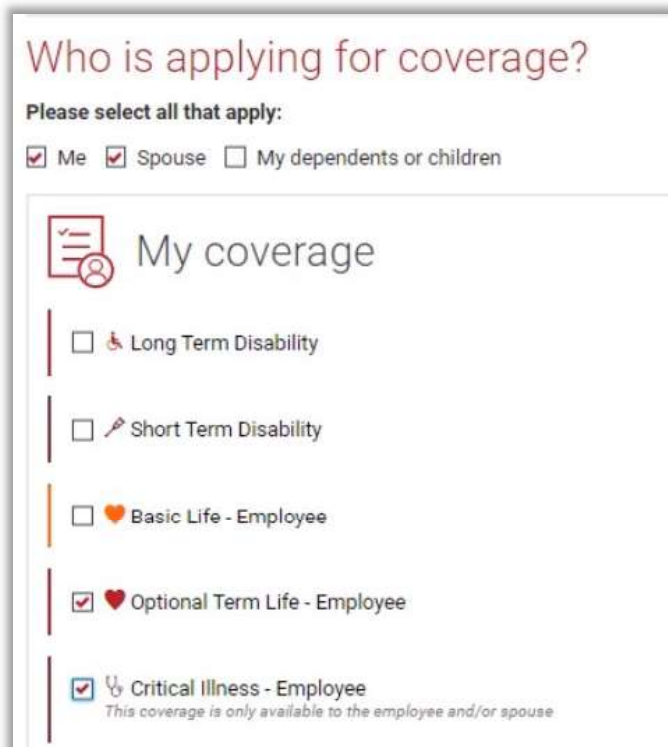
When a member receives the link, they will register using their name and Company Code is GROWMARK. Below are the steps to complete EOI.

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 'Evidence of Insurability' and 'Welcome, Jane'. Below this, there is a paragraph explaining that additional information is needed for insurance. A 'Need Help?' box is on the right. The main content area has a red header 'What do I need to know before starting my application?' with a sub-header '+ Information you will need, quick tips and saving your progress'. The first section is 'First, we need to verify your identity.' with a blue checkmark. It asks 'How would you like to verify your identity?' with radio buttons for 'Social security number' (selected) and 'Employee ID'. A text box for the social security number contains '*****' and a 'VERIFY' button is next to it. The second section asks 'Are you a new employee electing coverage for the first time?' with a blue checkmark and radio buttons for 'Yes' (selected) and 'No'. The final section says 'Thank you! Once you have read and agree to our online terms & conditions, you may begin your application.' with a blue checkmark. It includes a disclaimer and 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. The title is 'Who is applying for coverage?' and the instruction is 'Please select all that apply:'. There are three checkboxes: 'Me' (checked), 'Spouse' (checked), and 'My dependents or children' (unchecked). Below this is a section titled 'My coverage' with a list of options: 'Long Term Disability' (unchecked), 'Short Term Disability' (unchecked), 'Basic Life - Employee' (unchecked), 'Optional Term Life - Employee' (checked), and 'Critical Illness - Employee' (checked). A note at the bottom states 'This coverage is only available to the employee and/or spouse'.

Self-Bill Customers will be standardly set-up without a coverage amount field in the questionnaire, so coverage amounts will not show in their reporting. This will help mitigate confusion for self-bill customers, as Lincoln is underwriting the individual not the amount. You should have a conversation with the customer and customer's BenTech provider about EOI status reporting provided by Lincoln.

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?

Please provide the following:

PERSONAL INFORMATION

First name: Middle initial: Last name:

Social security number: Date of birth: Sex at birth: Birth state:

Marital status:
 Single Married Domestic partnership Civil Union

Height: Feet Inches Weight: lbs.

CONTACT INFORMATION

Select phone type: Phone number: Email:

Preferred method of communication:

Residential address

Residential address 1: Residential address 2 (Optional):

Residential city: Select State:

Postal code: Country:

Use my residential address

Mailing address

Mailing address 1: Mailing address 2 (Optional):

Mailing city: Select State:

Postal code: Country:

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.	<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

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 Yes	Full-time/part-time Full-time	Current annual salary \$150,000
Employee occupation asdf	Employee ID asdf	Date of hire 01/01/1980
Date of rehire		

PERSONAL INFORMATION [Edit](#)

First name Jane	Middle initial	Last name Employee
Social security number *****6789	Date of birth 01/01/1960	Sex at birth F
Birth state NE	Height: 5' 5"	Weight: 150 lbs
Marital status: Single		

CONTACT INFORMATION [Edit](#)

Phone type Work	Phone number (402) 123-4567	Email elkin425@jwlying.com
Preferred method of communication Email		
Residential address: Use my residential address		
Residential address 1 1234 Main St.	Residential address 2	
Country United States	State NE	Mailing city Omaha
		Zip code 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

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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

BACK
Delete application
Save for later
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

1. 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;
2. I authorize any required deductions from my pay;
3. 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;
4. 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

First, last name

Date: 02/12/2021

BACK
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

 The logo for Lincoln Financial Group, featuring a stylized profile of a person's head in a red square to the left of the text "Lincoln Financial Group" in a serif font.	Medical Underwriting Lincoln Financial Group P.O. Box 2870 Omaha, NE 68103-2870
You're In Charge®	
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