

# Evidence of Good Health Application

Apply online

at

[www.GuideStone.org](http://www.GuideStone.org)



| Seminary Students

  
**GuideStone**<sup>®</sup>  
Insurance Plans

*Do well. Do right.*<sup>®</sup>

### Use of form

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- This form must be typed or completed in blue or black ink. (Do not use red ink or pencil.)
- To avoid delay in the processing of your application, answer all questions.
- If you make any changes to the written information, date and initial any changes.
- Coverage is not guaranteed until approved in writing by GuideStone. Do not cancel your current coverage until you have been notified of approval by GuideStone and your GuideStone coverage is effective.

**Remember:**

- To sign and date the application.
- If your spouse or a dependent over the age of 18 is applying for coverage, he or she must sign both authorizations in Section G.
- Life and medical plans require evidence of insurability (unless you are eligible for open-enrollment). Underwritten plans will be effective on the date of approval. This process can take up to eight weeks, while required information is collected and reviewed.
- If you are applying for only dental, accidental death and dismemberment and/or personal accident coverage, you do not need to complete the medical information section (pages 6–11). These products are effective the day the application is received, regardless of underwriting requirements for life and medical.
- If you previously had medical coverage, you may have received a certificate of creditable coverage from your former employer or insurer. This certificate does not guarantee that you or your dependents will be approved for coverage. Coverage may be declined entirely as a result of the underwriting process. If you received a certificate of creditable coverage or evidence that shows you have creditable coverage, you should submit it to the Personal Plans in the enclosed envelope. Your creditable coverage may shorten a plan's pre-existing condition limitation period for you and any applicable dependents.
- To apply for GuideStone's life and health products as a seminary student, you must be enrolled in an official degree program intended to qualify you for a full-time position in a ministerial field, for example, Christian education, pastorate, theology, youth ministry, or children's ministry.
- If you experience a 63-day break in coverage between your previous health plan and enrollment into a GuideStone health plan, we are unable to credit your prior coverage towards your pre-existing condition limitation period with GuideStone. Therefore, the normal 12-month pre-existing condition limitation period will be applied. The only coverage that can be excluded during the pre-existing condition limitation period is coverage for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to your approval date.

**To maintain eligibility you must continue to meet the above requirements. Failure to do so could render you ineligible for GuideStone's life and health products.**

**After completing this form you may fax it to:**

214-720-4676

**Or return the completed form to:**

Insurance Operations — Personal Plans  
GuideStone Financial Resources, SBC  
2401 Cedar Springs Road  
Dallas, TX 75201-1498

**Or apply online at [www.GuideStoneInsurance.org](http://www.GuideStoneInsurance.org)**

**SECTION A – APPLICANT INFORMATION**

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First name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home telephone: (\_\_\_\_) \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Gender:  Male  Female      Marital status:  Single  Married

Email address: \_\_\_\_\_

**SECTION B – SCHOOL INFORMATION**

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School name: \_\_\_\_\_

School address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Initial registration date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Send billing to:  Student  Alternate contact      Degree plan: \_\_\_\_\_

Name of alternate contact: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**ABOUT OUR PLANS:**

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Unum Life Insurance Company of America and its duly authorized representatives insure and provide claims processing services for the term life, accident, and disability plans.

Case Professional Resources, LLC, provides individual applicant underwriting for the term life and disability plans.

CIGNA Dental provides claims processing for the Premier Dental Care and Choice Dental Care plans. Claim processing services for the Guided Dental HMO Plan vary by state.

Highmark Blue Cross Blue Shield® is the claims administrator for the Blue Cross Blue Shield PPO network. The official plan documents govern the actual operation of the plans.



**SECTION C – COVERAGE OPTIONS**

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**Student term life plan (Fill in one option only.)**

- |                                   |                                   |                                    |
|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$50,000  |
| <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$35,000 | <input type="checkbox"/> \$100,000 |
| <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$40,000 |                                    |
| <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$45,000 |                                    |
- 

**Spouse term life insurance**  Yes  No

Coverage amount: \$ \_\_\_\_\_

(Must be in \$5,000 increments up to a maximum of \$50,000. Not to exceed 50% of applicant term life amount.)

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**Child term life insurance (\$10,000)**  Yes  No

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**Medical**

I am applying for medical coverage for the following people who are not Medicare primary:

- For myself                       For spouse                       For eligible children

Select a medical plan:

- |   |   |
|---|---|
| <input type="checkbox"/> Seminarian Plan    | <input type="checkbox"/> Health Choice 1000 |
| <input type="checkbox"/> Health Choice 5000 | <input type="checkbox"/> Health Choice 500  |
| <input type="checkbox"/> Health Choice 3000 | <input type="checkbox"/> Health Today       |
| <input type="checkbox"/> Health Choice 2000 | <input type="checkbox"/> Health Saver 2800  |
- 

**Senior Plans**

I am applying for medical coverage for the following people who are Medicare primary:

- For myself                       For spouse                       For eligible children

Select a plan:

- Care Basic  
 Care Plus
- 

**Long-Term Care Solutions**

To help you make the best decisions regarding long-term care, GuideStone has selected LTC Financial Partners to provide you with professional long-term care education and planning tools. To obtain more information, please contact LTC Financial Partners at **1-877-LTC-4478** (1-877-582-4478) or visit [www.ltcguidestone.com](http://www.ltcguidestone.com).

**Long-Term Care insurance is available to eligible employees and their:**

- Spouses
- Parents
- Parents-in-law
- Adult children
- Grandparents

You must be actively employed at an SBC church for at least 20 paid hours per week.

**SECTION C – COVERAGE OPTIONS (CONTINUED)**

If you are only applying for one or more of the products listed below, you do not need to complete Section F: Applicant and dependent medical information.

**Accidental death & dismemberment**  Yes  No

(Term life insurance required. Coverage amount will equal applicant term life amount.)

**Personal accident insurance**

For myself:  Yes  No Coverage amount: \$\_\_\_\_\_ (Available to applicant in \$25,000 increments not to exceed \$500,000.)

For my spouse:  Yes  No (Coverage equal to 1/2 of applicant's personal accident insurance)

**Dental**

I am applying for dental coverage for the following people:  For myself  For spouse  For eligible children

Select a dental plan:

Premier Dental Care Plan

Choice Dental Care Plan

Guided Dental HMO Plan (If selecting this plan, indicate a dental office number in Section E for each covered person. Visit [www.CIGNA.com](http://www.CIGNA.com) for a complete list of participating dental offices.)

**Health Limited Plan**

I am applying for the Health Limited Plan for the following people:

For myself  For spouse  For eligible children

**SECTION D – BENEFICIARY DESIGNATION**

**Term life insurance (and AD&D if applicable)**

**Relationship**

**Birth date**

**Social Security number**

Primary beneficiary:\* \_\_\_\_\_ / / \_\_\_\_\_

Primary beneficiary:\* \_\_\_\_\_ / / \_\_\_\_\_

Secondary beneficiary:\* \_\_\_\_\_ / / \_\_\_\_\_

Secondary beneficiary:\* \_\_\_\_\_ / / \_\_\_\_\_

**Personal accident insurance**

**Relationship**

**Birth date**

**Social Security number**

Primary beneficiary:\* \_\_\_\_\_ / / \_\_\_\_\_

Contingent beneficiary:\* \_\_\_\_\_ / / \_\_\_\_\_

\* Show full given name

In order for minor child(ren) to receive a death benefit, a guardian must be legally appointed to administer the property.

**SECTION E – APPLICANT AND DEPENDENT INFORMATION**

Proof of dependent eligibility is **due within 60 days of approval** for GuideStone coverage. You **must** submit a copy of one of the following documents for each of your dependents as proof of their eligibility for enrollment in the GuideStone insurance program:

**For spouse and/or child(ren):**

- Notarized Certification of Dependent Eligibility form (this form)
- Current Tax Return (1040 only, black out financial data)
- Marriage License (for spouse only)

**For children only:**

- State issued birth certificate
- Adoption papers
- Court order establishing guardianship

Name (applicant) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship: Applicant Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Name (spouse) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship: Spouse Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Name (dependent) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship:  Child  Stepchild  Grandchild Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Name (dependent) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship:  Child  Stepchild  Grandchild Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Name (dependent) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship:  Child  Stepchild  Grandchild Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Name (dependent) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship:  Child  Stepchild  Grandchild Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Name (dependent) first: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth (country): \_\_\_\_\_

Gender:  Male  Female Relationship:  Child  Stepchild  Grandchild Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Dental office number: \_\_\_\_\_ Medicare primary?  Yes  No

Make copies of this page and complete to request coverage for additional dependents.

**SECTION E – APPLICANT AND DEPENDENT INFORMATION (CONTINUED)**

**Make copies of this page and complete to request coverage for additional dependents.**

2. Address of your dependents not residing with you, who are below the age of 25, who are not married and who are wholly dependent on you for support and maintenance.

DEPENDENT(S)	ADDRESS

**SECTION F – APPLICANT AND DEPENDENT MEDICAL INFORMATION**

**You must answer all medical questions. Failure to answer all questions thoroughly will result in return of the application to you for completion.**

1. Have you or any applicant ever applied and been rejected for any:

Medical policies  Yes  No

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

2. Life insurance policies  Yes  No

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

**SECTION F – APPLICANT AND DEPENDENT MEDICAL INFORMATION (CONTINUED)**

If you are applying for medical and/or term life coverage, complete Section F. You must answer all medical questions. Failure to answer all questions thoroughly will result in return of the application to you for completion.

**Part I.**

Please answer each question completely. If it is found that you have supplied materially incorrect or misleading enrollment eligibility information, or if it is proven that you have supplied fraudulent statements or fraudulent omissions, your subscription agreement may be voided.

1. Do you — or any family member applying — use any medical equipment (such as a walker, wheelchair, cane or hospital bed)?  Yes  No

2. Are you — or any family member applying — currently receiving home health care?  Yes  No

3. If you answered “yes” to question 1 or 2, please provide the name(s) of the affected person(s) and specifics about the condition:

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of person: \_\_\_\_\_ Reason: \_\_\_\_\_

4. Give date of last menstrual period for each female family member applying:

Name of person: \_\_\_\_\_ Date of last period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of person: \_\_\_\_\_ Date of last period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of person: \_\_\_\_\_ Date of last period: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Are you — or any family member applying — currently pregnant?  Yes  No

Name of pregnant person: \_\_\_\_\_ Date medically diagnosed or treated: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of pregnant person: \_\_\_\_\_ Date medically diagnosed or treated: \_\_\_\_/\_\_\_\_/\_\_\_\_

6. Have you — or any family member applying — gained or lost more than 20 pounds over the past 3 months?

Yes  No If “yes” provide the person’s name and amount gained or lost.

Name of person: \_\_\_\_\_ Weight gained / lost: \_\_\_\_\_

Name of person: \_\_\_\_\_ Weight gained / lost: \_\_\_\_\_

Name of person: \_\_\_\_\_ Weight gained / lost: \_\_\_\_\_

Name of person: \_\_\_\_\_ Weight gained / lost: \_\_\_\_\_

**Part II.**

Please indicate by checking the appropriate block(s) below if you — or any family member applying — have been treated by, diagnosed by or received medical advice from a physician or other health care provider for any condition, illness, injury or surgery listed below **within the last (5) years.**

**List dependents by name**

- Dependent 1 \_\_\_\_\_
- Dependent 2 \_\_\_\_\_
- Dependent 3 \_\_\_\_\_
- Dependent 4 \_\_\_\_\_
- Dependent 5 \_\_\_\_\_

**Under dependents applying for coverage mark each condition below as appropriate**

**Conditions**

	Applicant	Spouse	Dependent 1	Dependent 2	Dependent 3	Dependent 4	Dependent 5
7. AIDS or positive test for HIV, HTLV-III/LAV Antibodies (Leave this question blank if you have tested positive for HIV but have not developed symptoms of the disease AIDS.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Amputation of limb. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Arteriovenous Malformation (AVM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Other joint diseases.* <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Back disabilities*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Back pain — chronic*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Brain tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Cataract(s) <b>right:</b> _____ <b>left:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Chiropractic visits. <b>Specify number of visits:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Cholesterol. <b>Specify current reading:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Other liver disease. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Congenital anomalies and conditions. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Dementia, "senility" or increasing forgetfulness with age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Diabetes — controlled with diet <b>Specify current fasting blood sugar:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Diabetes — controlled with medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Ear conditions (including frequent ear infections). <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Other lung disease (including work related, for example, "Black Lung") <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Gynecological. <b>Specify:</b> _____ If recent delivery, please provide date of medical release (post-partum checkup) from obstetrician/gynecologist Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* If you check this condition, you must list under Part III or on a separate piece of paper the name(s) of the attending physician, osteopath or chiropractor and date(s) of treatment for each family member.

Dependent 1 \_\_\_\_\_

Dependent 2 \_\_\_\_\_

Dependent 3 \_\_\_\_\_

Dependent 4 \_\_\_\_\_

Dependent 5 \_\_\_\_\_

**Conditions**

- 34. Heart attack
- 35. Other heart disease
- 36. Hepatitis
- 37. High blood pressure (if checked, indicate usual blood pressure)
- 38. Infertility. **Specify:** \_\_\_\_\_
- 39. Immunization for children

Name and address of pediatrician:

\_\_\_\_\_

- 40. Kidney/renal failure
- 41. Other kidney disorder
- 42. Leukemia
- 43. Other hematologic (blood) disorder. **Specify:** \_\_\_\_\_
- 44. Musculoskeletal (pertaining to muscle or bone) injury or illness

**Specify:** \_\_\_\_\_

- 45. Neurological deficit or disorder, including head or spinal injury or paralysis. **Specify:** \_\_\_\_\_
- 46. Psychiatric disorder/behavioral health
- 47. Severe injury or burns. **Specify:** \_\_\_\_\_
- 48. Severe visual impairment/blindness
- 49. Spinal injuries
- 50. Stroke
- 51. Surgery of any kind. **Specify:** \_\_\_\_\_
- 52. Temporomandibular Joint Syndrome (TMJ)
- 53. Transient Ischemic Attacks (TIAs)
- 54. Urological

- 55. Any other conditions, injuries or ailments not specifically mentioned above for which you have been treated by, diagnosed by, or received medical advice from a physician or other health care provider within the last five (5) years?

	Applicant	Spouse	Dependent 1	Dependent 2	Dependent 3	Dependent 4	Dependent 5
34. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Other heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. High blood pressure (if checked, indicate usual blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Infertility. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Immunization for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Kidney/renal failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Other kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Other hematologic (blood) disorder. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Musculoskeletal (pertaining to muscle or bone) injury or illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Neurological deficit or disorder, including head or spinal injury or paralysis. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Psychiatric disorder/behavioral health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Severe injury or burns. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Severe visual impairment/blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Spinal injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Surgery of any kind. <b>Specify:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Temporomandibular Joint Syndrome (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Transient Ischemic Attacks (TIAs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Urological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please explain:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part III.**

If any sections in Part II are checked, please explain below. Use additional paper if necessary. Please provide details of the condition.

Patient's name/diagnosis Type of treatment/surgery	Hospital treatment?	Attending physician	Dates of illness
_____	<input type="checkbox"/> Inpatient	Name: _____	From: ___/___/___
_____	<input type="checkbox"/> Outpatient	Address: _____	To: ___/___/___
_____	Date: ___/___/___	Phone: ( ___ ) _____	
_____		Hospital name: _____	
_____	<input type="checkbox"/> Inpatient	Name: _____	From: ___/___/___
_____	<input type="checkbox"/> Outpatient	Address: _____	To: ___/___/___
_____	Date: ___/___/___	Phone: ( ___ ) _____	
_____		Hospital name: _____	
_____	<input type="checkbox"/> Inpatient	Name: _____	From: ___/___/___
_____	<input type="checkbox"/> Outpatient	Address: _____	To: ___/___/___
_____	Date: ___/___/___	Phone: ( ___ ) _____	
_____		Hospital name: _____	

When was the last time each person applying for coverage visited a doctor (other than in an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary.

NAME OF PERSON	DATE OF EXAM	FULL NAME, ADDRESS, AND TELEPHONE NUMBERS OF PROVIDERS	REASON
Applicant:	___/___/___		
Spouse:	___/___/___		
Dependent child:	___/___/___		
Dependent child:	___/___/___		
Dependent child:	___/___/___		

When was the last time each person applying for coverage visited an emergency room at a hospital/or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

NAME OF PERSON	DATE OF EXAM	FULL NAME, ADDRESS, AND TELEPHONE NUMBERS OF DOCTORS AND HOSPITALS	REASON
Applicant:	___/___/___		
Spouse:	___/___/___		
Dependent child:	___/___/___		
Dependent child:	___/___/___		
Dependent child:	___/___/___		

**Part IV.**

If you — or any family members applying:

Drink alcoholic beverages, please indicate frequency of use:

Name of person	Number of drinks per week (Serving size per drink equals 1½ oz. liquor, 12 oz. beer, 5 oz. wine)
_____	_____
_____	_____
_____	_____

Have ever smoked. Please indicate amount of cigarettes, cigars, pipes, or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use:

Name of person	Amount per day/type	Dates of use:
_____	_____	From: ___/___/___ To: ___/___/___
_____	_____	From: ___/___/___ To: ___/___/___
_____	_____	From: ___/___/___ To: ___/___/___

Have taken prescribed drugs within the last year. Please list drugs taken and reason:

Name of person	Medication/dosage	Condition/reason	Dates of use
_____	_____	_____	From: ___/___/___ To: ___/___/___
_____	_____	_____	From: ___/___/___ To: ___/___/___
_____	_____	_____	From: ___/___/___ To: ___/___/___
_____	_____	_____	From: ___/___/___ To: ___/___/___

**SECTION G – APPLICANT AND DEPENDENT AUTHORIZATIONS**

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**Please read this information carefully. Make a copy of the entire application and retain it for your records.**

**Unum Life Insurance Company of America (Unum) and its duly authorized representatives.**

**Case Professional Resources, LLC**

**GuideStone Financial Resources of the Southern Baptist Convention (GuideStone)**

When your request for coverage is evaluated by any of the above companies, they need to ask you questions about the health and medical history of each person for whom you request coverage. In addition, you are also requested to authorize any physician or hospital to provide each of these companies with reports, if necessary, about the health of each person. In some instances, each company may require a physical examination or other tests.

**Caution:** If your answers on this application are incorrect or untrue, Unum and its duly authorized representatives, Case Professional Resources, LLC, or GuideStone may deny benefits or rescind your insurance or other coverage, limited to the contestability period. Any person who, knowingly or with intent to defraud or deceive GuideStone or any insurance company, submits an application for insurance or other coverages containing any materially false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy or other coverages for which evidence of insurability or good health is required. I have read and understand the statements above and understand I am entitled to a copy.

**Print name of applicant (employee):** \_\_\_\_\_

**Signature (employee):** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Signature of spouse:** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_  
**(if to be covered for life or medical)**

**Signature of child age 18 and over:** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_  
**(if to be covered for life or medical)**

**Signature of child age 18 and over:** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_  
**(if to be covered for life or medical)**

**This application is not complete unless the authorization on the next page is signed by the applicant and dependents over 18 applying for coverage.**

**AUTHORIZATION**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or medically related facility or service; insurance company; insurance service provider; third-party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications and perform administration functions for Unum Life Insurance Company of America and its duly authorized representatives, Case Professional Resources, LLC, and GuideStone Financial Resources of the Southern Baptist Convention, (collectively referred to as "Recipients"). Information about my health may relate to any disorder of the immune system including HIV; use of drugs and alcohol; mental and physical history, condition, advice or treatment, but does not include psychotherapy notes. This authorization excludes divulging whether a test for HIV has been conducted and the results of such test. Such test will not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that an applicant has AIDS/ARC.

I understand that any information recipients obtain pursuant to this authorization will be used for evaluating and processing my application for coverage and performing plan administration functions. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent recipients have relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand that if I revoke this authorization, recipients may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to the address to HIPAA Privacy Contact, GuideStone Financial Resources, SBC, 2401 Cedar Springs Road, Dallas, TX 75201-1498.

I understand if I do not sign this authorization or if I alter its content in any way, recipients may not be able to evaluate or process my application and this may be the basis for denying my application.

**Print name of applicant (employee):** \_\_\_\_\_

**Signature (employee):** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Signature of spouse:** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Signature of child age 18 and over:** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

(if to be covered for life or medical)

**Signature of child age 18 and over:** \_\_\_\_\_ **Social Security number:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

(if to be covered for life or medical)

**Information about the individual's personal or legal representative, if applicable**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

If signing on behalf of another, please include the proper documentation that attests to your ability to sign (death certificate, court-stamped Letters of Appointment of the Executor of Estate, proof of custody, power of attorney, etc.).

# Certification of Dependent Eligibility Personal Plans

Proof of dependent eligibility is **due within 60 days of approval** for GuideStone coverage. You **must** submit a copy of one of the following documents for each of your dependents as proof of their eligibility for enrollment in the GuideStone insurance program:

**For spouse and/or child(ren):**

- Notarized Certification of Dependent Eligibility form (this form)
- Current Tax Return (1040 only, black out financial data)
- Marriage License (for spouse only)

**For children only:**

- State issued birth certificate
- Adoption papers
- Court order establishing guardianship

Participant first name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Daytime telephone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employer (or school) name: \_\_\_\_\_ Employer account number: \_\_\_\_\_

Employer telephone: (\_\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

**DEPENDENTS**

I am legally married to \_\_\_\_\_,

Spouse Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse Social Security number: \_\_\_\_\_

I am the guardian of each dependent listed below, and these dependents are younger than age 25, unmarried, and dependent on me for support and maintenance. *Additional eligibility criteria are listed in our Plan Booklets online at [www.GuideStoneInsurance.org](http://www.GuideStoneInsurance.org). A printed copy may be requested by calling 1-888-98-GUIDE (1-888-984-8433):*

Dependent Name	Date of Birth	Social Security Number
	____/____/____	
	____/____/____	
	____/____/____	
	____/____/____	

(additional dependents may be listed on the back of this form)

I certify that the above dependents meet the eligibility requirements for GuideStone coverage. I acknowledge that failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s) and GuideStone may require reimbursement for claims paid on behalf of ineligible enrollees.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Notarization** (REQUIRED when legal documentation is not returned with this form):

**Notary Seal:**

Acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

Notary Public: \_\_\_\_\_ State: \_\_\_\_\_ My commission expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

This form or supporting documents may **be faxed to 214-720-4676 or mailed to:** Insurance Operations — Personal Plans  
GuideStone Financial Resources, SBC  
2401 Cedar Springs Road  
Dallas, TX 75201-1498

**GUIDESTONE USE ONLY**

Approved by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_





2401 Cedar Springs Road, Dallas, TX 75201-1498  
1-888-98-GUIDE • [www.GuideStone.org](http://www.GuideStone.org)