

Apply Online at www.GuideStone.org

Evidence of Good Health Application

✧ Personal Plans




GuideStone[®]
Insurance Plans

Do well. Do right.[®]

Evidence of Good Health Application

Personal Plans

- **Use this form for enrollments. To get a quote, call 1-888-GUIDE (1-888-984-8433) or visit www.GuideStoneInsurance.org and Get A Quote.**
- 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 the 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.

Important Application Information

- Sign and date the application.
- **Life, medical, and disability plans require evidence of insurability and 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 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 age 19 and over.
- 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 pre-existing condition limitation rule does not apply to covered participants under the age of 19. 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.

Eligibility Requirements

In order to apply for GuideStone's life and health products you must be considered an "eligible employee."

You are considered an "eligible employee" if:

- You are an employee of a church, agency or institution affiliated with the Southern Baptist Convention; or that shares the common religious bonds with the Southern Baptist Convention; and
- You work 20 or more hours per week; and
- You receive a salary.

Or:

- You are an employee serving at two churches, agencies or institutions affiliated with the Southern Baptist Convention; or that shares the common religious bonds with the Southern Baptist Convention; and
- Your combined hours worked for both employers equal at least 20 hours per week; and
- You receive a salary.

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.GuideStone.org

What generated your most recent interest in GuideStone's plans? (check one)

- Direct mail
- Phone call
- Referred by: _____
- Convention/conference
- Web site *www.GuideStone.org*
- Other: _____
- Print ad
- Promotional code: _____

SECTION A – EMPLOYEE INFORMATION

Check one: I work for an SBC church/ministry I work for a church/ministry that shares the common religious bonds with the SBC

I am applying for: Self Spouse Eligible children

First name: _____ MI: _____ Last: _____

Social Security number: _____

Gender: Male Female Birth date: ____/____/____ Marital status: Married Single

Daytime telephone: (_____) _____ E-mail address: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Have you graduated from or attended a seminary or Bible college affiliated with the Southern Baptist Convention within the last 12 months? Yes No

If yes, name of school: _____ Date last attended or graduated: ____/____/____

SECTION B – EMPLOYER VERIFICATION

Employer name: _____ Employer account number: _____

Telephone number: (_____) _____ Fax number: (_____) _____

Association: _____

Employer Tax ID number (EIN): _____ Email address: _____

Employer's physical address: _____

City: _____ State: _____ ZIP Code: _____

Billing address if different from the employer's physical address:

Address: _____

City: _____ State: _____ ZIP Code: _____

Employment date: ____/____/____ Occupation: _____ Total annual salary: _____

The undersigned employer representative confirms that this applicant is a paid employee of the above named organization, working 20 or more hours per week, and that the reported salary, if provided, is accurate. We understand that the addition of the products being requested by this applicant, upon approval, will be added to our employer's monthly billing statement. **(The employer representative cannot be the applicant.)**

Signature of employer representative: _____ Date: ____/____/____

Title: _____ Contact phone: (_____) _____

ABOUT OUR PLANS:

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 GuideStone PPO medical plans and provides medical underwriting services.



SECTION C – COVERAGE OPTIONS

Term Life Insurance (Maximum coverage is \$750,000). Choose only one option:

- | | | | | |
|---|---|-----------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> 1 times salary | <input type="checkbox"/> 5 times salary | OR | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$35,000 |
| <input type="checkbox"/> 2 times salary | <input type="checkbox"/> 6 times salary | | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$40,000 |
| <input type="checkbox"/> 3 times salary | <input type="checkbox"/> 7 times salary | | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$45,000 |
| <input type="checkbox"/> 4 times salary | <input type="checkbox"/> 8 times salary | | <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$50,000 |
| | | | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$100,000 |
-

Spouse term life insurance Yes No

Coverage amount: \$ _____

(Must be in \$5,000 increments up to a maximum of \$250,000. Not to exceed 50% of applicant term life amount.)

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

Disability

Because short-term and long-term disability plans are designed to work together, you must select the appropriate coordinating plans if you wish to request both a short-and long-term disability plan: select both Economy plans, both Choice plans, or both Premier plans. Note: Because this product is salary based, salary information is required.

Long-term disability

Short-term disability

- | | |
|----------------------------------|----------------------------------|
| <input type="checkbox"/> Economy | <input type="checkbox"/> Economy |
| <input type="checkbox"/> Choice | <input type="checkbox"/> Choice |
| <input type="checkbox"/> Premier | <input type="checkbox"/> Premier |
-

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"/> 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"/> Basic Health 5000 |
| <input type="checkbox"/> Health Choice 1000 | <input type="checkbox"/> Health Saver 2800 |
-

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.

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

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

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. These non-underwritten products are effective immediately upon receipt of your application.

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 ID number in Section E for each covered person. Visit 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:*	_____	____/____/____	_____
Contingent beneficiary:*	_____	____/____/____	_____
Contingent beneficiary:*	_____	____/____/____	_____

Personal accident insurance

	Relationship	Birth date	Social Security number
Primary beneficiary:*	_____	____/____/____	_____
Primary beneficiary:*	_____	____/____/____	_____
Contingent beneficiary:*	_____	____/____/____	_____
Contingent beneficiary:*	_____	____/____/____	_____

*Show full given name

SECTION E – EMPLOYEE AND DEPENDENT INFORMATION

1. Employee must complete this section for yourself and each person for whom you are requesting any coverage (i.e., life, disability, or medical): If you elect to enroll in the Guided Dental HMO Plan, please provide a dental ID number for each family member. If you do not provide a dental ID number, the dental plan will automatically assign one to you. If you then decide to change providers, it may take 6–8 weeks before the change is effective.

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 (on page 15)
- 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 (employee) first: _____ MI: _____ Last: _____

Social Security number: _____ Birth date: ____/____/____ Place of birth (country): _____

Gender: Male Female Relationship: Applicant Height: _____ Weight: _____

Dental ID 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 ID number: _____ Medicare primary? Yes No

Name (dependent) first: _____ MI: _____ Last: _____

Social Security number: _____ Birth date: ____/____/____ Place of birth (country): _____

Gender: Male Female Relationship: Child Other _____ Height: _____ Weight: _____

Dental ID number: _____ Medicare primary? Yes No

Name (dependent) first: _____ MI: _____ Last: _____

Social Security number: _____ Birth date: ____/____/____ Place of birth (country): _____

Gender: Male Female Relationship: Child Other _____ Height: _____ Weight: _____

Dental ID number: _____ Medicare primary? Yes No

Name (dependent) first: _____ MI: _____ Last: _____

Social Security number: _____ Birth date: ____/____/____ Place of birth (country): _____

Gender: Male Female Relationship: Child Other _____ Height: _____ Weight: _____

Dental ID number: _____ Medicare primary? Yes No

2. Address of your dependents not residing with you and who are under the age of 26:

DEPENDENT(S)	ADDRESS

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

SECTION F – EMPLOYEE AND DEPENDENT MEDICAL INFORMATION

If you are applying for medical, term life and/or disability 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.

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

1. Medical policies Yes No

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: _____

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: _____

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

Spouse _____

Dependent 1 _____

Dependent 2 _____

Dependent 3 _____

Dependent 4 _____

Dependent 5 _____

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

Conditions

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.)

8. Alcoholism

9. Alzheimer's Disease

10. Amputation of limb. **Specify:** _____

11. Arteriovenous Malformation (AVM)

12. Arthritis

13. Other joint diseases.* **Specify:** _____

14. Asthma

15. Back disabilities*

16. Back pain — chronic*

17. Brain tumor

18. Cancer

19. Cataract(s) **right:** _____ **left:** _____

20. Chest pain or angina

21. Chiropractic visits. **Specify number of visits:** _____

22. Cholesterol. **Specify current reading:** _____

23. Cirrhosis

24. Other liver disease. **Specify:** _____

25. Congenital anomalies and conditions. **Specify:** _____

26. Dementia, "senility" or increasing forgetfulness with age

27. Diabetes — controlled with diet

Specify current fasting blood sugar: _____

28. Diabetes — controlled with medication

29. Drug dependency

30. Ear conditions (including frequent ear infections).

Specify: _____

31. Emphysema

32. Other lung disease (including work related, for example, "Black Lung")

Specify: _____

33. Gynecological. **Specify:** _____

If recent delivery, please provide date of medical release (post-partum checkup) from obstetrician/gynecologist

Date: ____/____/____

	<i>Employee</i>	<i>Spouse</i>	<i>Dependent 1</i>	<i>Dependent 2</i>	<i>Dependent 3</i>	<i>Dependent 4</i>	<i>Dependent 5</i>
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. Specify: _____	<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.* Specify: _____	<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) right: _____ left: _____	<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. Specify number of visits: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Cholesterol. Specify current reading: _____	<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. Specify: _____	<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. Specify: _____	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify current fasting blood sugar: _____	<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).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____	<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")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Gynecological. Specify: _____	<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.

Conditions

Employee *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. Specify: _____ | <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. Name and address of pediatrician: | <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. Specify: _____ | <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
Specify: _____ | <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. Specify: _____ | <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. Specify: _____ | <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. Specify: _____ | <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"/> |

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?

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: ___/___/___	Telephone: (_____) _____	
_____		Hospital name: _____	
_____	<input type="checkbox"/> Inpatient	Name: _____	From: ___/___/___
_____	<input type="checkbox"/> Outpatient	Address: _____	To: ___/___/___
_____	Date: ___/___/___	Telephone: (_____) _____	
_____		Hospital name: _____	
_____	<input type="checkbox"/> Inpatient	Name: _____	From: ___/___/___
_____	<input type="checkbox"/> Outpatient	Address: _____	To: ___/___/___
_____	Date: ___/___/___	Telephone: (_____) _____	
_____		Hospital name: _____	

Section below must be completed by all applicants.

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 DOCTORS AND HOSPITALS	REASON
Employee:	___/___/___		
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
Employee:	___/___/___		
Spouse:	___/___/___		
Dependent child:	___/___/___		
Dependent child:	___/___/___		
Dependent child:	___/___/___		

Part IV.

Medication History – List each applicant

Have taken prescribed drugs within the last year, please list drugs taken and reason:

Name of person	Medication/dosage	Condition/reason	Dates of use
_____ <input type="checkbox"/> N/A	_____	_____	From: ___/___/___ To: ___/___/___
_____ <input type="checkbox"/> N/A	_____	_____	From: ___/___/___ To: ___/___/___
_____ <input type="checkbox"/> N/A	_____	_____	From: ___/___/___ To: ___/___/___
_____ <input type="checkbox"/> N/A	_____	_____	From: ___/___/___ To: ___/___/___

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: ___/___/___
_____	_____	From: ___/___/___ To: ___/___/___

SECTION G – APPLICANT AND DEPENDENT AUTHORIZATIONS

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

Highmark Blue Cross Blue Shield®

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 employee: _____

Signature (employee): _____ **Social Security number:** _____ **Date:** ____/____/____

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

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

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

Signature(s) 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 of 26. *Additional eligibility criteria are listed in our Plan Booklets online at 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