Medical History Statement

Northwestern Mutual®

Group Insurance Administration
Post Office Box 2177, Portland, OR 97208-2177
Telephone (800) 378-4665

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 3. Keep a copy for your records, and send the original to Northwestern Mutual at the address given above.

MEMBER/EMPLOYEE INFORMATION

Name of Group		Group Number	Check who is Applying (One per form) ☐ Member/Employee ☐ Spouse ☐ Child
Member/Employee Name		Birth Date (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)				Email Address
Street Address	City		State/Province	ZIP/Postal Code
Sex ☐ M ☐ F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

Check the type and provide details on the amount of coverage you are requesting.

☐ Short Term Disability

☐ Long Term Disability ________ Current Amount In Force, if any + ________ Additional Amount Requested = ________ Total Amount Requested

☐ Life ________ Current Amount In Force, if any + ________ Additional Amount Requested = ________ Total Amount Requested

☐ Dependents Life ________ Current Amount In Force, if any + ________ Additional Amount Requested = ________ Total Amount Requested

PHYSICIAN INFORMATION *(Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)*

Doctor First Name	Doctor Last Name		
Clinic Name		Doctor Phone	
Doctor Address	City	State/Province	ZIP/Postal Code
Date Last Consulted			
Reason Last Consulted			

Applicant Name	Social Security Number

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

1. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? ☐ Yes ☐ No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal disorder, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? ☐ Yes ☐ No
   - E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back or spine, or arthritic conditions? ☐ Yes ☐ No
   - H. Endocrine (including thyroid or adrenal), diabetes? ☐ Yes ☐ No
   - I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or HIV antibodies? ☐ Yes ☐ No
4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease, disorder, condition or injury? ☐ Yes ☐ No
5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, illness, injury, surgery or pregnancy? ☐ Yes ☐ No
6. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than cold or allergies not disclosed above? ☐ Yes ☐ No

Height ______________________ **Weight** ______________________

DETAILS OF ANY "YES" ANSWERS ABOVE

Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.

Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

Applicant Name	Social Security Number

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any supplemental information, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Northwestern Mutual of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Northwestern Mutual, the effective date of any coverage will be determined in accordance with the terms of the Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Northwestern Mutual's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to Northwestern Mutual or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that Northwestern Mutual will use information to determine my eligibility for group insurance coverage. I understand Northwestern Mutual may release information it has about me to its reinsurers and to any person performing business or legal services for Northwestern Mutual in connection with my application. I authorize Northwestern Mutual to release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit Northwestern Mutual's reporting. I understand Northwestern Mutual may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to Northwestern Mutual pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to Northwestern Mutual is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to Northwestern Mutual, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair Northwestern Mutual's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Policy(ies), and my coverage will be subject to all terms and conditions of the Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

Signature of Applicant (or Member/Employee for Dependent Child)	**Date**

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Northwestern Mutual.

Applicant Name	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. I authorize Northwestern Mutual or its reinsurers to make a brief report of my personal health information to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

  Northwestern Mutual may release information in its file to its reinsurers, and Northwestern Mutual, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Northwestern Mutual, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-378-4665.

FRAUD NOTICE

- ALABAMA , ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who kindly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- KANSAS: Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- LOUISIANA, NEW MEXICO: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- MAINE, OHIO: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- MARYLAND, RHODE ISLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- TENNESSEE, VIRGINIA, WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Authorization to Release Health-Related Information TO THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY

Group Insurance Administration
Post Office Box 2177, Portland, OR 97208-2177
Telephone (800) 378-4665

This authorization complies with the HIPAA Privacy Rule.

- I authorize any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record to The Northwestern Mutual Life Insurance Company (Northwestern Mutual), its reinsurers or its representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.
- I understand that the information disclosed to Northwestern Mutual pursuant to this authorization is subject to redisclosure and is no longer covered by the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA). I understand that Northwestern Mutual will use the information obtained by this authorization to determine my eligibility for group disability insurance coverage. I further authorize Northwestern Mutual to release this information to its reinsurers, the MIB, Inc. (MIB), or other insurance companies to which I have applied for insurance coverage or benefits, or any person performing services for Northwestern Mutual in connection with my application.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid for one year from the date below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that except to the extent that My Providers have relied upon this authorization to disclose requested records, I have a right to revoke this authorization at any time by sending a written statement to Northwestern Mutual at the address above. I understand that the revocation of the authorization, or the failure to sign the authorization may impair Northwestern Mutual's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

Name ______________________________ (please print)   ______________________ Date of Birth

______________________________ Signature of Applicant   ______________________ Date

This Authorization is a two-page document. Some states' rules concerning authorizations change the terms and provisions above. The terms and provisions on page 2 of this document are part of this Authorization and apply in the identified states. Your signature above acknowledges that the Authorization includes the applicable state variations listed on page 2 of this Authorization.

Northwestern Mutual®

AUTHORIZATION TO RELEASE HEALTH-RELATED INFORMATION
State Variations

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

Arizona

With respect to Northwestern Mutual's disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.

California

This Authorization includes information on the diagnosis or treatment of AIDS, but excludes information on prior testing for HIV.

Maine

This Authorization excludes disclosure of the result of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this Authorization from including the fact the applicant has AIDS.

Minnesota

This Authorization excludes the release of information about **HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus)** tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

New Mexico

This Authorization extends to Confidential Abuse Information. Confidential Abuse Information means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship.

Oklahoma

We are required to inform you that the information you authorize for release may include records which may indicate the presence of communicable or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Vermont

This Authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The proposed insured/applicant IS NOT authorizing the company to forward the results from any new test requested by the company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

Authorization to Release Health-Related Information TO THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY

Group Insurance Administration
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Name ______________________________ ______________________
(please print) Date of Birth

______________________________ ______________________
Signature of Applicant Date

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New Mexico

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Oklahoma

We are required to inform you that the information you authorize for release may include records which may indicate the presence of communicable or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

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