

EVIDENCE OF INSURABILITY
EMPLOYEE ONLY GROUP LIFE COVERAGE



1. This form must be completed if an employee is applying for supplemental life coverage (or additional supplemental life coverage) after the initial 30 days from date of hire.

EMPLOYEE NAME	SSN or IDENTIFICATION #	DATE OF BIRTH
HOME ADDRESS	PHONE	EMAIL ADDRESS
(STREET) (CITY) (STATE) (ZIP)	HEIGHT	WEIGHT

2. FULL NAME AND ADDRESS OF FAMILY PHYSICIAN: _____

3. PLEASE ATTACH FULL DETAILS FOR EVERY "YES" ANSWER.

Have you ever had, been treated, or diagnosed by a physician or medical professional for:

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Anemia, leukemia or any blood disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | 19. Back disorders, chronic low back pain, disk disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Any disability, injury or bodily deformity..... | <input type="checkbox"/> | <input type="checkbox"/> | 20. Cataract, visual loss, otitis media or ear disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Arthritis or rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | 21. Temporomandibular Joint (TMJ) Treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Asthma, emphysema, COPD or a chronic breathing disorder.. | <input type="checkbox"/> | <input type="checkbox"/> | 22. Acquired Immune Deficiency Syndrome (AIDS) or AIDS | | |
| 5. Cancer, tumor, or any abnormal growth | <input type="checkbox"/> | <input type="checkbox"/> | Related Complex (ARC)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes or sugar in urine (current insulin dosage.....) | <input type="checkbox"/> | <input type="checkbox"/> | 23. Any other condition, disorder, illness or disease for which | | |
| 7. Seizures, epilepsy, loss of consciousness or fainting spells.... | <input type="checkbox"/> | <input type="checkbox"/> | further diagnostic tests, consultation, observation, treatment | | |
| 8. Goiter or thyroid disorder | <input type="checkbox"/> | <input type="checkbox"/> | or surgery or hospitalization has been recommended | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Hernia, hemorrhoids or varicose veins | <input type="checkbox"/> | <input type="checkbox"/> | 24. Infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Heart attack, angina or other heart disorders | <input type="checkbox"/> | <input type="checkbox"/> | Other: | | |
| 11. Stroke, paralysis or circulatory disorders | <input type="checkbox"/> | <input type="checkbox"/> | 25. Any reason to believe you are pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Hypertension or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you used tobacco or nicotine in any form in the past | | |
| 13. Liver or gallbladder disorder, jaundice or gallstones | <input type="checkbox"/> | <input type="checkbox"/> | two years | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Kidney stone, kidney, bladder or prostate disorder | <input type="checkbox"/> | <input type="checkbox"/> | If yes, please specify..... | | |
| 15. Endometriosis, fibroids, prolapse, abnormal female bleeding | | | 27. Do you take Medicine prescribed by a | | |
| or menstrual disorder | <input type="checkbox"/> | <input type="checkbox"/> | physician?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Psychiatric, nervous or mental disorder, depression, | | | If yes, please list..... | | |
| recurrent headaches, migraine | <input type="checkbox"/> | <input type="checkbox"/> | 28. Are you currently a resident in a custodial center | | |
| 17. Chemical dependency or alcoholism or been treated for the | | | or nursing home? | <input type="checkbox"/> | <input type="checkbox"/> |
| use of alcohol or drugs..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. Ulcers, ulcerative colitis, Crohn's disease, stomach or | | | | | |
| intestinal disorders | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Question Number	Details or Condition – Give date, duration, and severity	Name and Address of each Physician, Hospital, etc. (PRINT)

I certify that statements made herein are true. I have read both sides of this application. I understand and agree that any false statements made here shall void any contracts issued based on this application.

4. Applicant Signature _____ Date _____

No right is created by the completion of this application and the same shall not be considered accepted unless the contract is actually issued to you.

The information you furnish on your application, including medical history, is the initial source of information about your health status when applying for coverage.

In seeking more information, you may be asked to request medical and health information records and reports from your physician, other medical care providers or professionals, hospitals, clinics, or other medically related facilities or suppliers. The medical and health information requested may include history, physical and laboratory findings, diagnosis, prognosis, and treatment records related to any past or recent physical or mental condition.

We treat the information we gather about you in a confidential manner, using it in connection with the administration of underwriting services only. Information in your file may be seen by our administrators, employees and in certain cases, our legal counsel only when there is a legitimate need. Personal information about you will not be disclosed without your authorization.