EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA), a Cigna Company
(herein called the Insurance Company)
P.O. Box 20310
Lehigh Valley, PA 18003-9924

For info and customer service, call 1-800-732-1603
- *All information must be completed by the applicant.*
- *He/she must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*
- *The Insurance Company must approve your request for insurance before it becomes effective.*
- *Be sure to make a copy for your records.*

Important: *Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink).*

EMPLOYER _____ **POLICY** _____

MANDATORY DATA NEEDED: In order to process this application, this information must be completed and returned to Cigna P.O. Box 20310 Lehigh Valley, PA 18003-9924 Fax: 1-800-440-0856

CLASS _____ **LOCATION/ PAYCODE #** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____ **VERIFIED BY** _____

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **ONGOING ENROLLMENT EVENT** ❑ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

EMPLOYEE SECTION

Employee Name: _____

Home Address _____ City _____ State _____ Zip _____

Gender: _____ **Birthdate** _____ **Social Security #** _____
Month/Day/Year

Day Phone _____ Evening Phone _____

COMPLETE IF ELECTING SPOUSE COVERAGE

Spouse Name _____

Home Address _____ City _____ State _____ Zip _____

Gender _____ Birthdate _____ Social Security # _____
Month/Day/Year

Day Phone _____ Evening Phone _____

❑ I am currently married and my date of marriage is _____

Applicant's Name _____ **Social Security #** _____

IMPORTANT
Please complete each section that follows if it is needed. Each section states when it is needed. Read the Agreements and Authorization section. Sign and date the form in the space provided.

SECTION A

Complete the employee information in this section if you (i.e., the Employee) are:

- applying for Life insurance for yourself that is greater than the guaranteed issue amount, or
- applying for Life insurance for yourself more than 31 days after you were eligible for the insurance.

Complete the spouse information if:

- applying for Life insurance for your spouse that is greater than the guaranteed issue amount, or
- applying for Life insurance for him/her more than 31 days after the spouse was eligible for the Life insurance.

Height and Weight Information

Employee			**Spouse**		
Height	ft	in	Height	ft	in
Weight	lbs		Weight	lbs	

PHYSICIAN INFORMATION SECTION

Employee Physician
Name _____ Phone No _____
Street Address _____ City _____ State _____ Zip _____
Date of Last Visit _____

Physician
Name _____ Phone No _____
Street Address _____ City _____ State _____ Zip _____
Date of Last Visit _____

Spouse Physician
Name _____ Phone No _____
Street Address _____ City _____ State _____ Zip _____
Date of Last Visit _____

Spouse Physician
Name _____ Phone No _____
Street Address _____ City _____ State _____ Zip _____
Date of Last Visit _____

SECTION B

Complete the employee information in this section if you (i.e., the Employee) are:

- applying for Life insurance for yourself that is greater than the guaranteed issue amount, or
- applying for Life insurance for yourself more than 31 days after you were eligible for the insurance.

Complete the spouse information in this section if:

- applying for Life insurance for your spouse that is greater than the guaranteed issue amount, or
- applying for Life insurance for him/her more than 31 days after the spouse was eligible for the Life insurance.

Please indicate your answers for each question in this section by checking the Yes or No box for the question. The questions in Section E must also be answered.

Within the last 5 years has the proposed insured been:

a) diagnosed with any of the conditions shown in this Section,
b) told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
c) or been treated by a medical professional for any of the conditions shown in items A through J below?

		Employee		**Spouse**	
		Yes	**No**	**Yes**	**No**
A.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑	❑	❑
B.	Diabetes, glandular condition, Hepatitis, Cirrhosis of the liver, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C.	Asthma, Chronic Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD),or any other condition affecting the lungs or respiratory tract?	❑	❑	❑	❑
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑	❑	❑

Applicant's Name _____ **Social Security #** _____

SECTION B

Complete the employee information in this section if you (i.e., the Employee) are:

- applying for Life insurance for yourself that is greater than the guaranteed issue amount, or
- applying for Life insurance for yourself more than 31 days after you were eligible for the insurance.

Complete the spouse information in this section if:

- applying for Life insurance for your spouse that is greater than the guaranteed issue amount, or
- applying for Life insurance for him/her more than 31 days after the spouse was eligible for the Life insurance.

Please indicate your answers for each question in this section by checking the Yes or No box for the question. The questions in Section E must also be answered.

Within the last 5 years has the proposed insured been:

a) diagnosed with any of the conditions shown in this Section,
b) told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
c) or been treated by a medical professional for any of the conditions shown in items A through J below?

		Employee		Spouse	
		Yes	No	Yes	No
E.	Human Immunodeficiency Virus infection, Acquired Immune Deficiency Syndrome, or any other condition affecting the immune system or lymph nodes?	❑	❑	❑	❑
F.	Stroke, Transient Ischemic Attack (TIA), Alzheimer's Disease, Paralysis, Epilepsy, fainting, Seizures, headaches, or other condition affecting the nervous system?	❑	❑	❑	❑
G.	Anemia or any other condition affecting the blood; Lupus, Arthritis, deformity or loss of limb?	❑	❑	❑	❑
H.	Anxiety disorder, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I.	Cancer, (other than Nonmelanoma Skin Cancer) Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J.	Alcohol or drug abuse or dependency?	❑	❑	❑	❑

SECTION C

Within the last 5 years has the proposed insured:

		Employee		Spouse	
		Yes	No	Yes	No
A.	Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑
B.	Smoked cigarettes, cigars, pipe, or used any tobacco product within the past 12 months?	❑	❑	❑	❑
	1. Specify type of tobacco product				
	2. For how many years has the proposed insured smoked?	_____		_____	
	3. If smoking tobacco: Approximately how many cigarettes or cigars are, or were, smoked on average per day?	_____		_____	
	4. If smoking tobacco: If cigarette or cigar smoking has been discontinued, when (month and year) did the proposed insured quit smoking?	_____		_____	
C.	Used any controlled or illegal drug or other substance?	❑	❑	❑	❑
D.	Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑	❑	❑
E.	Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑	❑	❑
F.	Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑	❑	❑

Use the space below to explain or provide further details to any "Yes" answers. If more space is needed, use a separate piece of paper and attach it to this form. Remember to Sign and Date any other attachments. Please initial all changes to any answers.

Name of Insured	*Condition*	*Date Occurred*	*Details of Condition, Treatment, Medication Prescribed and Duration of Treatment*	*Current Status*

Applicant's Name _____ **Social Security #** _____

AGREEMENTS

To the best of my knowledge and belief all written, telephonic and electronic information I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

1. This request will be a part of the policy that provides the insurance.
2. I must report any change in my health that happens before the insurance is effective.
3. I must report any change in the health of my spouse for whom coverage is requested that happens before the insurance is effective.
4. Requested insurance above any guaranteed issue amount will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

AUTHORIZATION

I hereby authorize any physician, medical professional, hospital or other medical facility, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity, the Medical Information Bureau (MIB) or any other person or organization to provide access to or copies of any medical records or other information, including motor vehicle driving record, relating to me or my spouse, to my employer's Plan Administrator and to their authorized representatives including Life Insurance Company of North America. I understand that this information may include, but is not limited to, information concerning: mental illness, psychiatric, substance abuse or use, disability, HIV testing and illness, Acquired Immune Deficiency Syndrome, and genetic testing, but does not include psychotherapy notes. If my employer, union, group association sponsors any other plans, whether or not underwritten or administered by Life Insurance Company of North America, or its affiliates, the information and/or records obtained may also be shared with the underwriting company insurer or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

I understand that the information will be used to assess my request for insurance. It may only be used for the purposes stated above if the information is re-disclosed. Any information provided to a third-party as permitted by this Authorization may not be re-disclosed by that third-party without my Authorization or unless allowed or required by law.

This authorization will remain in effect for a period of Two (2) years. If I wish to obtain a copy of this Authorization, I and/or my authorized agent may receive a copy upon request.

I am aware that I may cancel this authorization at any time by written notice to the Insurance Company at the address at the top of this Application form. If I cancel this Authorization, it will not: (1) change any action taken in reliance on the Authorization up to that date; or (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that information disclosed under this authorization by the recipient is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). The Insurance Company is subject to the Gramm-Leach-Bliley Act and state privacy laws. The Insurance Company may not disclose protected information except as permitted by those laws or as authorized by me.

Caution: *Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.*

☛

Sign Here _____ _____ _____ _____

Employee's Signature *Month/Day/Year* *Spouse's Signature (If applying for insurance for your spouse)* *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.