CIGNA Group Insurance
Life • Accident • Disability

EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America

CIGNA Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18002-0310

For information and customer service call 1-800-732-1603.

- This form cannot be considered unless received within 30 days of completion.
- All questions must be answered completely by the applicant and the form must be dated and signed.
- Insurance for an applicant will not be effective unless and until the Insurance Company has accepted this evidence as satisfactory.
- The information on this form will be considered current for no longer than 90 days.
- Please print (preferably in black ink).

POLICY NO.________________ **CLASS**_______

EMPLOYER__________________________________ **PAYCODE**_______________ **BILLING LOCATION**__________

EMPLOYEE Mr. Mrs. Ms. Name ______________ ______________________ Social Security #___________________ Birthdate __________
First Last

Address____ City__________________________ State_________ Zip____________

Work Phone __________________ Home Phone _____________________ Sex: M F Height: ____ft ____in Weight: ______lbs

Date of Hire_______________ Base Annual Salary ___________________ Occupation ___________________ Email Address ____________________

Optional Insurance–Amount Requested: Employee $______________

Primary Physician Name ________________________________ Address____________________________________ Phone __________________

COMPLETE QUESTIONS A-L BELOW

During the last five years, has the proposed insured been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in the questions below?

	Employee Yes	Employee No
A. Cysts, moles, warts, polyps, cancer or tumor?		
B. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?		
C. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?		
D. Ever been medically treated for, been medically advised, or sought to have treatment for alcoholism or drug use or dependency?		
E. Any mental, emotional or any other nervous disorders?		
F. Is there a current use of prescribed medications by the proposed insured?		
G. Ever been diagnosed with or been treated for AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?		
H. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through G?		
I. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease/disorder of the nervous system?		
J. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?		
K. Any surgical operation performed or been advised to have any performed?		
L. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions A through K?		

Use the space below to provide details for "Yes" answers given above and/or medical impairments listed in questions A-L. Complete and attach a separate sheet of paper if additional space is required. Please sign and date the attachment.

Condition	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

EVIDENCE OF INSURABILITY FORM

Name ______________________________ **Social Security #**______________

❖❖ AGREEMENTS AND AUTHORIZATIONS ❖❖

To the best of my knowledge and belief, all written, telephonic and electronic information I provided is true and complete. I also understand that the insurance I have selected for myself will begin on the effective date, provided I am actively at work on that date. If I am not, the effective date of my personal coverage will be delayed until I am actively at work. I understand that insurance subject to medical questions requires insurance company approval, and additional medical information, including blood work, may be required to approve such insurance. I understand that I am responsible to report to the insurance company any change in my health prior to my coverage effective date, and that no coverage will be effective unless I meet the insurance company's underwriting requirements on the effective date.

Caution: *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.*

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of me or my health to give any such information to Life Insurance Company of North America and its authorized representatives and reinsurers, for use in the processing and evaluation of my application and eligibility for life or disability insurance coverage. This authorization extends to and includes information or records pertaining to psychiatric, drug or alcohol use history.

This authorization shall be valid for a period of 30 months from the date signed, and a photographic copy shall be as valid as the original. I understand that my authorized representative or I have the right to receive a copy of the authorization upon request. I understand that this authorization may be revoked provided such revocation is in writing. However, such revocation will not affect any action taken in reliance on the authorization. I further understand that this authorization is being given as a condition of obtaining insurance, and that any revocation does not affect the insurer's right to use this authorization in connection with the contest of a claim or of the policy in accordance with applicable law.

Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the Health Insurance Portability and Accountability Act. (The insurance companies are subject to the Gramm-Leach-Bliley Act and state privacy laws and do not disclose any protected information except as permitted by those laws.)

Pre-Existing Condition Limitation (applies to long-term disability insurance only): I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the 3 months just prior to the coverage effective date) unless the disability begins more than 12 months after the effective date of coverage.

Sign Here

______________________________ ____/____/____

Employee's Signature *Date*

TL-006069 (5/97) PA

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 insurers' privacy practices is available upon request.

Be sure to make a copy of your application for your own records.