## EVIDENCE OF INSURABILITY FORM



Lehigh Valley, PA 18003

PO Box 20310

Life Insurance Company of North America (LINA) (herein called the Insurance Company)

For info and customer service call

• The applicant must sign and date this form.

•	This form	r cannot	be considered	unless recei	ived within	30 days	of the d	date it is	dated.
Ir	nportant:	Please	enter all dates	in mm/dd/yy	yy format.				

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.							
Employer:	Policy:						
Class: Location: Date of Hire:	Annual Salary: Verified By:						
Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.)							
VOLUNTARY COVERAGE	EMPLOYEE AMOUNT SPOUSE* AMOUNT						
1. Enter Requested Coverage Amount (Total)							
2. Enter Current Coverage including guarantee issue (enter zero if no current coverage	nge)						
3. Subtract Line #2 from Line # 1, this is the amount subject to Underwriting							
EMPLOYEE SECTI	ON						
Employee Name (first, middle, last)	Social Security #						
Address City	State Zip						
Phone ID # Birt	ihdate Gender: 🗅 M 🗅 F						
COMPLETE IF ELECTING SPOU	SE* COVERAGE						
□ I am currently married and my date of marriage is:	-or- 🔲 I currently have an eligible Domestic Partner						
Spouse* Name: (first, middle, last)							
Phone Birthdate	Gender: 🗖 M 🗖 F						
IMPORTANT							
Please complete each section that follows.							
Read the Agreements and Authorization. Sign and	date the form in the space provided.						
Complete the employee and spouse information in this section if you (i.e., the Employ than the guaranteed amount or are applying for Life Insurance more than 31 days after the section of							
Height and Weight Info	ormation						
<i>Employee</i> Heightftin. Weightlbs.	<i>Spouse*</i> Height <u>ft.</u> in. Weight <u>lbs</u> .						
PHYSICIAN SECT	ION						
Employee Physician Name	Phone Number						
Street Address City _	State Zip						
	Phone Number						
Street Address City	State Zip						

Name

Social Security #\_\_\_\_\_

\_\_\_\_

	Section A: Please indicate your answers for each question in this section by checking the Yes or No box for the	e questi	on.		
1.	Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the	Empl	oyee	Spou	se*
	conditions:	Yes	No	Yes	No
Α.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?				
Β.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?				
C.	Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?				
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?				
E.	HIV infection, AIDS, 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?				
Η.	Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?				
Ι.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?				
J.	Alcohol or drug abuse or dependency?				

	SECTION B: Please indicate your answers for each question in this section by checking the Yes or No box for the	e questi	on.				
		Empl	oyee	Spou	se*		
1. W	/ithin the last 5 years has the proposed insured:	Yes	No	Yes	No		
А.	Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?						
В.	Smoked cigarettes:						
	1. For how many years has the proposed insured smoked?						
	2. Approximately how many cigarettes are, or were, smoked on average per day?						
	3. If cigarette 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?						
	If you answered "Yes" to any questions above, please provide de	etails in	the ta	able be	low.		
Use	Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.						

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.					
Name of Employee, Spouse*	Medical Condition	Date Occurred	Duration/Treatment Received	Current Status	

## AGREEMENTS AND AUTHORIZATION

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 may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) I must report any change in my health that happens before the insurance is effective.

(5) Requested insurance 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 permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (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 info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

\*For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.

*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 fact material 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.