EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America

CIGNA Group Insurance
Life · Accident · Disability

CIGNA Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924

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.
- In order to process this form, your employer must verify the information in the Employer Use box.
- Please print (preferably in black ink).

POLICY NO. LK-030402 **CLASS**

Employer Use: **EMPLOYER** Sura / Jefferson Lab **WORKSITE** **BILLING LOCATION**

Existing Voluntary Coverage: Employee $ **Spouse $** **Child(ren) $** **Verified by**

EMPLOYEE ☐Mr. ☐Mrs. ☐Ms. Name _____ (First) _____ (Last) Social Security # _____ Birthdate _____

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 $_____ Child(ren) $_____

Primary Physician Name _____ Address _____ Phone _____

SPOUSE (IF ELECTING COVERAGE) ☐I am currently married and my date of marriage is _____

Spouse Name _____ (First) _____ (Last) Social Security # _____ Birthdate _____

Height: _____ft _____in Weight: _____lbs Sex: ☐M ☐F Occupation _____

Optional Insurance–Amount Requested: Spouse $_____

Spouse Primary Physician Name _____ Address _____ Phone _____

COMPLETE QUESTIONS A-K BELOW ⇧ **Before returning this form to your employer, please fold and staple the bottom half of the form to this line to conceal your answers to the medical questions 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		Spouse		Child/ren	
	Yes	No	Yes	No	Yes	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. Any alcohol and/or drug addiction and/or substance abuse; mental, emotional or any other nervous disorders?	☐	☐	☐	☐	☐	☐
E. Is there a current use of prescribed medications by the proposed insured?	☐	☐	☐	☐	☐	☐
F. 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?	☐	☐	☐	☐	☐	☐
G. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through F?	☐	☐	☐	☐	☐	☐
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease/ disorder of the nervous system?	☐	☐	☐	☐	☐	☐
I. 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?	☐	☐	☐	☐	☐	☐
J. Any surgical operation performed or been advised to have any performed?	☐	☐	☐	☐	☐	☐
K. 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 J?	☐	☐	☐	☐	☐	☐

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

Name of Employee/Spouse/Child	*Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

Friday, February 25, 2005 (2).max

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, as well as dependent coverage, will be delayed until I am actively at work. Also, if any one of my dependents to be insured is not performing normal daily activities* on the effective date, that coverage will be delayed until the date the dependent resumes normal daily activities. 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.

Authorization: If proposed for insurance, I authorize the following parties with any records or knowledge of personal information, medical history, mental or physical condition, diagnosis or treatment of me, to give such information to Life Insurance Company of North America, its authorized representatives or reinsurers. The authorized parties include any licensed physician, medical practitioner, hospital, clinic, Veterans Administration or other medically related facility, insurance company, employer, the Medical Information Bureau, or other organization, institution or person. For the purposes of collection and use of information to evaluate my application for insurance, I agree that my authorization is valid for thirty (30) months from the date of my signature below.

I understand that disclosures may be made without my consent as permitted by law. I also understand that the Insurer, its authorized representatives or reinsurers may make a brief report about my health or medical information listed above to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If I apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of my request, the Bureau will arrange disclosure of any information it may have in my file. If I question the accuracy of information in the file, I may contact the Bureau and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The Bureau's information office address is P.O. Box 105, Essex Station, Boston, MA 02112. Telephone: 617.426.3660.

A copy of this authorization will be valid as the original. I understand that my authorized representative or I have the right to receive a copy of this authorization upon request. My authorized representative or I can revoke this authorization at any time, subject to the rights of an individual who acted in reliance on this authorization prior to notice of revocation. The revocation must be in writing, signed and dated by my authorized representative or me.

Electronic/Telephonic Authorization: I authorize the insurance company to accept my telephonic and electronic elections and change requests, as allowed by law. The insurance company will not be legally responsible for any liability if acting in good faith upon any instructions given by telephonic or electronic means, or for the authenticity of such instructions.

* ***Normal Daily Activities*** for a spouse and child are defined as follows: A spouse or child will not be deemed able to do normal tasks if he or she: a) is a patient in a hospital; or b) is confined at home under the care of a doctor for sickness or injury; or c) has had his or her level of activity significantly reduced so that he or she requires human supervision or assistance to perform any of the following Activities of Daily Living: mobility, transferring, feeding, dressing or toileting, which another person of the same age could normally perform; or d) is receiving any disability benefits from any source due to any sickness or injury.

I certify that I have read the completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Sign Here

_____ ___/___/___ _____ ___/___/___

Employee's Signature *Date* *Spouse's Signature (if applying for insurance)* *Date*