## **EVIDENCE OF INSURABILITY FORM**

Life Insurance Company of North America

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.

CIGNA Group Insurance

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.

Please print (preferably in black ink).				***************************************	0. <i>LK-03040</i> 2		
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Existing Voluntary Coverage: Employee \$	5 Sp	ouse \$	Ch	ild(ren) \$		Verified by	
EMPLOYEE ☐ Mr. ☐ Mrs. ☐ Ms. Name _	First	Last	Socia	Security#		Birthdate	
Address		City			State	7in	
Work Phone Home P	hone	S	ex: M F	Height:	ftin	Weight: lbs	
Date of Hire Base Annual S	Salary	Occ	upation	d d	_ Email Address_		
Optional Insurance–Amount Requested: E	mployee \$	(	Child(ren) \$	-			
Primary Physician Name	<i>,</i>	Address	n a		Phone		
SPOUSE (IF ELECTING COVERAGE)	I am currently married	and my date of	of marriage is				
Spouse Name	Train danonly married and my date of me					Birthdate	
Height:ftin Weight:lb			tion				
Optional Insurance-Amount Requested: Spous		_1 Осоцра	uon				
Spouse Primary Physician Name		- Address			Phon	ne	
COMPLETE QUESTIONS A-K BELOW	of the form to th	is line to cor	nceal vour ans	wers to the m	nedical duestin	e bottom half 介	
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## EVIDENCE OF INSURABILITY FORM

Name	Social Security #	1
+ A	GREEMENTS AND AUTHORIZATIONS +	
the insurance I have selected for myself will begin of my personal coverage, as well as dependent cov is not performing normal daily activities* on the activities. I understand that insurance subject to including blood work, may be required to approve in my health prior to my coverage effective date requirements on the effective date.	n, telephonic and electronic information I provided is true and complete. I also understant on the effective date, provided I am actively at work on that date. If I am not, the effective crage, will be delayed until I am actively at work. Also, if any one of my dependents to be in effective date, that coverage will be delayed until the date the dependent resumes normal medical questions requires insurance company approval, and additional medical inform such insurance. I understand that I am responsible to report to the insurance company any classical and that no coverage will be effective unless I meet the insurance company's underways and that no coverage will be effective unless I meet the insurance company's underways.	e date sured daily ation hange vriting
history, mental or physical condition, diagnosis of authorized representatives or reinsurers. The aut Administration or other medically related facility,	orize the following parties with any records or knowledge of personal information, more treatment of me, to give such information to Life Insurance Company of North American parties include any licensed physician, medical practitioner, hospital, clinic, Vet insurance company, employer, the Medical Information Bureau, or other organization, institution information to evaluate my application for insurance, I agree that my authorization is are below.	ca, its terans
or reinsurers may make a brief report about my profit membership organization of life insurance another Bureau Member Company for life or heal request, will supply such company with the infinitering information it may have in my file. If I question	my consent as permitted by law. I also understand that the Insurer, its authorized representate although the medical information listed above to the Medical Information Bureau (MIB), a companies, which operates an information exchange on behalf of its members. If I apply himsurance coverage, or a claim for benefits is submitted to such a company, the Bureau, ormation in its file. Upon receipt of my request, the Bureau will arrange disclosure on the accuracy of information in the file, I may contact the Bureau and seek a correction of the accuracy of information in the file, I may contact the Bureau and seek a correction of the file of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second of the Bureau and seek a correction of the second	non- ply to upon of any ion in
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Electronic/Telephonic Authorization: I authorize as allowed by law. The insurance company will relephonic or electronic means, or for the authorize	e the insurance company to accept my telephonic and electronic elections and change requot be legally responsible for any liability if acting in good faith upon any instructions give city of such instructions.	iests, en by
she: a) is a patient in a hospital; or b) is confined a significantly reduced so that he or she requires hum	are defined as follows: A spouse or child will not be deemed able to do normal tasks if a home under the care of a doctor for sickness or injury; or c) has had his or her level of act an supervision or assistance to perform any of the following Activities of Daily Living: mob nother person of the same age could normally perform; or d) is receiving any disability ber	tivity oility,
I certify that I have read the completed application in loss of coverage under the policy.	n and that I realize that any false statement or misrepresentation in the application may r	esult
Sign Here		
MF		
Employee's Signature	Date Spouse's Signature Date (if applying for insurance)	