



## Evidence of Insurability Form

<b>Part 1: To be completed by the Group Administrator/Policyholder</b>			
Group/Policyholder Name			Group Number
Street Address	City	State	Zip Code
<b>Type/Amount of Insurance Requested:</b>			
<input type="checkbox"/> Basic Life _____ <input type="checkbox"/> Supplemental Life _____ <input type="checkbox"/> Voluntary Life _____ <input type="checkbox"/> Short Term Disability _____ <input type="checkbox"/> Long Term Disability _____ <input type="checkbox"/> Other (please specify) _____			
<b>Type/Amount of Applicant's Current Coverage(s):</b> _____			
<b>Applicant's Current Base Annual Earnings (for Salary Based Benefits):</b> _____ <b>Employee's Date of Hire:</b> _____			
<b>Reason for Evidence of Insurability:</b> <input type="checkbox"/> Amount in excess of Non Medical Maximum <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other: _____			
Authorized Representative Name	Authorized Representative Signature	Authorized Representative Title	

<b>Part 2: To be completed by Consumers Life Insurance Company</b>	
<input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Other: _____ Non Medical Amount: _____	<input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Unable to Approve <input type="checkbox"/> Amount Approved: _____ <input type="checkbox"/> Effective Date: _____ Reviewed By: _____            Date: _____

<b>Part 3: To be completed by the Applicant – Separate forms are required for each Applicant</b>						
Employee Name	First	MI	Last	Insurance is for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Applicant Name	First	MI	Last	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Smoker <input type="checkbox"/> Non Smoker	Date of Birth
Street Address	City		State	Zip Code	State of Birth	
Business Telephone Number	Home Telephone Number	E-mail Address				
Employee's Social Security Number			Applicant's Social Security Number			

**YOU MUST COMPLETE BOTH PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.**



Applicant Name: \_\_\_\_\_

**Part 3: (continued)**

**Medical Information – Please check either “Yes” or “No” in answer to each question below. “You” and “Your” refers to the Proposed Insured. Provide details to all “yes” answers in Part 4. Omitted information will cause delays.**

1. Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches      Weight: \_\_\_\_\_ Lbs.
2. Are you now:
  - a. pregnant? .....  Yes     No
  - b. taking prescribed medications or on a prescribed diet? .....  Yes     No
  - c. receiving or applying for any disability benefits including workers’ compensation? .....  Yes     No
3. In the past 5 years, have you received medical treatment or counseling by a physician for the use of alcohol, prescribed drugs or non-prescribed drugs? .....  Yes     No
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If “yes,” specify date of conviction: \_\_\_\_\_ .....  Yes     No
5. Have you ever been diagnosed or treated by a physician or other health care provider for:
  - a. Chest pain or heart trouble? .....  Yes     No
  - b. High blood pressure, stroke or circulatory disorders? .....  Yes     No
  - c. Cancer or tumors? .....  Yes     No
  - d. Anemia, Leukemia or other blood disorder? .....  Yes     No
  - e. Diabetes?     Yes     No    If yes, Insulin treated? .....  Yes     No
  - f. Asthma, Tuberculosis, Pneumonia or other lung disease? .....  Yes     No
  - g. Ulcers, stomach or liver disorder? .....  Yes     No
  - h. Colitis, Crohn’s or any intestinal disorder? .....  Yes     No
  - i. Epilepsy, paralysis or dizziness? .....  Yes     No
  - j. Mental or nervous disorder? .....  Yes     No
  - k. Lyme disease, Epstein-Barr or Chronic Fatigue Syndrome? .....  Yes     No
  - l. Arthritis, carpal tunnel, or any muscle weakness? .....  Yes     No
  - m. Kidney or urinary tract disorder? .....  Yes     No
  - n. Thyroid or other gland disorder? .....  Yes     No
  - o. Back, neck or spinal disorder? .....  Yes     No
6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immune Deficiency Virus (HIV) infection? .....  Yes     No

**Part 4: To be completed by the Applicant**  
Provide details of all “YES” answers given to questions in Part 3. If additional space is required, attach a separate signed and dated sheet.

Question #	Illness/Reason for Checkup or Doctor’s Treatment/Consult	Dates From    To	Full name, address and telephone # of Attending Physician or Other Practitioner

**This Evidence of Insurability Form is incorporated and made part of the enrollment application.**

**Applicant Name:** \_\_\_\_\_

**WARNING:** 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. (Not enforceable in Oregon or Virginia.)

**AGREEMENTS & AUTHORIZATION:** I, the undersigned applicant, have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Consumers Life Insurance Company (CLIC) shall not be liable for any claim arising prior to the date of approval of this application at CLIC's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, prescription history database supplier, pharmacy benefit manager, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to CLIC's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize CLIC to disclose the information obtained in the consideration of my application for insurance to its reinsurers any prescription history database supplier and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation must be in writing and will have no effect on any actions taken by CLIC prior to receipt of the revocation;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until CLIC approves my application, provided that I am eligible for coverage per the terms of the policy on that day;
- I have a right to access and correction with respect to all personal information collected.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from CLIC.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, CLIC has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



*(Please detach and retain with your insurance records)*

Thank you for enrolling for Group Insurance with Consumers Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Consumers Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Consumers Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.