COMBINED INSURANCE COMPANY OF AMERICA Home Office: [Chicago, Illinois]

Group Term Life Evidence of Insurability

I. BASIC INFORMATION				
Group Policyholder:		Group Policy Number:		Date
EMPLOYEE'S (Proposed Insured) NAME (First MI Last)		☐ Male ☐ Female	Birthdate: Mo/Day/Yr	Age
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)		[Work Phone No.]	[Social Security No.]	Employee ID#
[Home Phone No.]	[Mobile Phone No.]	Email		
EMPLOYER NAME			Hire Date: Mo/Day/Yr	[Gross Annual Income]
Occupation				

Name(s)	**DOB: Mo/Day/Yr**	**Relationship**	**Sex**
Employee	**(as above)**	**Self**	**(as above)**
		Spouse	M ☐ F ☐
		Child 1	M ☐ F ☐
		Child 2	M ☐ F ☐
		Child 3	M ☐ F ☐
		Child 4	M ☐ F ☐

IMPORTANT – READ CAREFULLY

II. EMPLOYEE SECTION

I represent and affirm the following:

1. In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy? ☐ Yes ☐ No
2. Have you been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS-related complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
3. Within the past 6 months have you had a blood pressure reading of 140/90 or higher, been told your blood pressure is uncontrolled, or has your physician added an additional blood pressure medication to your treatment regimen? ☐ Yes ☐ No
4. Within the past 5 years, have you been diagnosed with diseases or disorders related to, been counseled, consulted, or treated by a doctor, including surgery, for any of the following: ☐ Yes ☐ No
   a. Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; hemophilia; phlebitis? ☐ Yes ☐ No
   b. Any mental or psychiatric disorder; Multiple Sclerosis; Parkinson's Disease; stomach or intestinal disorder; Crohn's Disease; Ulcerative Colitis? ☐ Yes ☐ No
   c. Cerebrovascular disease, muscular dystrophy, and any other neurological disorder or disorder of the nervous system? ☐ Yes ☐ No
   d. Stroke or Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
   e. Emphysema, other disease of lungs, or respiratory organs? ☐ Yes ☐ No
   f. End stage renal disease; disease of kidney? ☐ Yes ☐ No
   g. Cancer, and/or cancerous tumor, including skin cancer? ☐ Yes ☐ No
   h. Cirrhosis, alcoholism or drug habit? ☐ Yes ☐ No

III. SPOUSE AND CHILD SECTION

[Complete question 1 if applying for life insurance on your spouse and/or child(ren).]

[Complete questions 1 and 2 if applying for life insurance above [$20,000] on your spouse and/or above [$10,000] on your child(ren).]

	Spouse	Child(ren)
1. Is the proposed insured currently disabled or confined to a medical facility due to an injury or illness other than as a result of a cold, the flu, back problems or strained/sprained/fractured/broken limb?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 12 months, has the proposed insured been hospitalized on an in-patient or outpatient basis, or treated by a physician due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb, routine physical or as a result of pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No

It is very important that you review your evidence of insurability carefully. Misstatements or omissions could cause an otherwise valid claim to be denied.

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Evidence of Insurability will not be disclosed to the employer or any other person without the authorization of the proposed insured.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, medically related facility, insurance company, or consumer reporting agency to release to Combined Insurance Company of America any information regarding me or my past or present health for the purpose of evaluating this Evidence of Insurability for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to Combined.

I understand that any insurance will not take effect unless and until Combined Insurance Company of America approves my enrollment. If coverage cannot be issued as requested under the rules of the company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums). This authorization may be revoked at any time.

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Evidence of Insurability is true and complete to the best of my knowledge and belief.

I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules.

[This form may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the form, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this form will be attached and made part of the Policy.]

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X _____ City: _____ State: _____ Date: ____ / ____ / ____

Signature of Employee

I, the authorized agent, have on the date of application recorded the information as given to me by the Employee.

Signature of Licensed Agent _____ Code # _____ % Split_____

Agent's Name and Florida License Identification No. (Please Print)_____