Evidence of Insurability Form

For Group Term Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability Insurance

Anthem Life & Disability Insurance Company

AnthemLife

PO Box 182361
Columbus, OH 43218-2361
Phone 800-551-7265
Fax 614-433-8880

Please print in ink or type.

Group no.

Evidence required because of:	This evidence is provided for:
☐ Over guaranteed issue amount ☐ Late entrant ☐ Change of benefits	☐ An effective date under a new group ☐ A post group effective date addition

SECTION 1: GENERAL INFORMATION

Last name	First name	M.I.	Date of birth (MM/DD/YYYY)

Social Security no.	State of birth	Height	Weight	Employee email

Name of employer	Work phone no.	Home phone no.

SECTION 2: DEPENDENT INFORMATION – Complete for all dependents (if any) to be covered under this program

Name (Include first and middle. Include last name only if different from Employee's)	Height	Weight	Date of birth (MM/DD/YYYY)	State of birth	Gender	Relationship	Full-time student	Eligible Income Tax Exemption
					☐ M ☐ F	SPOUSE		
					☐ M ☐ F		☐ Yes ☐ No	
					☐ M ☐ F		☐ Yes ☐ No	

SECTION 3: MEDICAL AND ACTIVITIES QUESTIONNAIRE

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program. To the best of the applicant's knowledge and belief:

1. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, who?____________________
   Expected due date________________(MM/DD/YYYY)
2. Do you or any of your dependents smoke or use tobacco? ☐ Yes ☐ No
   If yes, who ____________________
   Type ____________________
3. In the past 10 years, has anyone ever:
   a. Had high blood pressure or high cholesterol? ☐ Yes ☐ No
      If yes, last three readings______ ______ ______
   b. Had heart disease, cancer, diabetes, arthritis, or asthma? ☐ Yes ☐ No
   c. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition? ☐ Yes ☐ No
   d. Been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated? ☐ Yes ☐ No
4. Has anyone ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex ARC)? (You are not required to disclose whether you have been tested or tested positive for HIV) ☐ Yes ☐ No
5. In the past 3 years has anyone been prescribed medication? ☐ Yes ☐ No
6. In the past 10 years have you or any of your dependents had an inpatient admission and/or outpatient surgery? ☐ Yes ☐ No
7. During the past 3 years, have you or any of your dependents sought medical treatment, or been advised by a medical or social practitioner to seek treatment for any condition not indicated by the answers to the preceding six questions? ☐ Yes ☐ No
8. Have you or any of your dependents ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? If yes, name of person, date and reason:____________________ ☐ Yes ☐ No
9. In the past 3 years, have you or any of your dependents been engaged in or contemplate during the next 12 months being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? ☐ Yes ☐ No
   Please list: ____________________

IMPORTANT NOTICE: No person, including an employee or agent of Anthem Life & Disability has the authority to change or omit any of these medical questions.

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Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este document.

SECTION 3: MEDICAL AND ACTIVITIES QUESTIONNAIRE (continued)

If you answered yes to any questions 3 through 7, provide details below.
If additional space is needed, please attach a separate page including your signature and date.

Question no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital

SECTION 4: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

SECTION 5: AGREEMENT AND AUTHORIZATION

I understand that, in order for Anthem Life & Disability Insurance Company to accept or decline this application, all of the information requested on the application must be completed. I understand that this application will be attached to and made part of the certificate of coverage. I realize that Anthem Life & Disability reserves the right to accept or decline this application (or to accept only certain persons for coverage) and that no right whatsoever is created by this application.

Authorization to release information:
I/We authorize any of the entities listed herein to give Anthem Life & Disability, and through it, to its affiliates and any administrators, reinsurers, agents, or other entities providing services on behalf of Anthem Life & Disability, and to the MIB Group, Inc. any data or records in the entities' possession about me (or any dependents listed herein), and my mental or physical health (or that of any dependents listed herein), except drug and alcohol treatment information.

This authorization is for: any medical practitioner; hospital; clinic or other medically related facility or provider of health services; pharmacy related service organization; insurance company; the MIB Group, Inc.; or any other organization, institution, or person that has data on me or my health. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person(s) who signs this form may have a copy of it upon request.)

The information gathered will be used for purposes which include: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. I/We understand that Anthem Life & Disability may furnish this information to the group or its representative. Anthem Life & Disability may also furnish information to other entities, which may include but is not limited to third party administrators, insurers, and government agencies. Anthem Life & Disability will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, reproductive health, information relating to AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider.

I/We have received and read a copy of Anthem Life & Disability's notices about the MIB and Notice of Exchange of Information. I/We understand that I/We may ask to be interviewed for this report. I/We understand that an Investigative Consumer report may be made. I/We hereby authorize such a report.

I/We also understand that I/We have a right to see and correct personal information that Anthem Life & Disability collects about me, and that I/We may receive a more detailed description of my rights under this law by writing to Anthem Life & Disability. This authorization will be valid from the date signed for a period of twenty four months. I may revoke this authorization at any time by sending a written request to Anthem Life & Disability.

I certify that I have read, or have had read to me, the completed application and that all information is true and complete to the best of my knowledge. I understand that any material misrepresentation or significant omission may result in an otherwise valid claim to be denied under any insurance issued from this application, subject to the incontestability provision of the policy.

Applicant signature **X**	Date (MM/DD/YYYY)
Signature of Spouse (If to be covered) **X**	Date (MM/DD/YYYY)
Signature of dependent (If to be covered and over the age of 14 years, 6 months) **X**	Date (MM/DD/YYYY)

Fraud Warning For Health Insurance Coverage: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.