## EVIDENCE OF INSURABILITY FORM



Lehigh Valley, PA 18003

PO Box 20310

Life Insurance Company of North America (LINA) (herein called the Insurance Company)

For info and customer service call

• The applicant must sign and date this form.

•	This form	cannot	be considered	unless re	eceived I	within .	30 days	of the	date i	t is da	ated.
Ir	mportant:	Please	enter all dates	in mm/da	d/yyyy fol	rmat.					

Employer Use: (Mandatory Data Needed) In or	der to process this form, th	ne employer must d	complete this information	п.					
<b>Delie</b> u									
Employer: Location:	Data of Lline	Annual Ca	Policy:						
Reason for Request: (i.e. New Hire, Late Entrant, Initial/	Dngoing Enrollment, etc.)								
VOLUNTARY COVERAGE		EMF	PLOYEE AMOUNT	SPOL	JSE* A	MOUN	Γ		
1. Enter Requested Coverage Amount (Total)	1. Enter Requested Coverage Amount (Total)								
2. Enter Current Coverage including guarantee issue (enter zero if no current coverage)									
3. Subtract Line #2 from Line # 1, this is the ar	-								
	EMPLOYEE S	SECTION							
Employee Name (first, middle, last)			Social Security #						
Address									
Phone ID # _		Birthdate		Gender	: 🗆 N				
	COMPLETE IF ELECTING	SPOUSE* COVERA	AGE						
□ I am currently married and my date of marriage is:									
Spouse* Name: (first, middle, last)									
Phone	Birthdate			Gender	ΠM	ΒF			
	IMPORT	ANT							
	Please complete each s								
Read the Agreements and Authorization. Sign and date the form in the space provided.									
Complete the employee and spouse information i	n this section if you (i.e. the l	Employee) or your s	nouse* are applying for Lit	fe Insura	nce tha	t is area	ator		
Complete the employee and spouse information in this section if you (i.e., the Employee) or your spouse* are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.									
	Height and Weigh	nt Information							
Employee Heightftin.	Neightlbs.	Spouse*	Heightftin.	Veight	lb	S.			
Please indicate your answers for each question in this section by checking the Yes or No box for the question.									
1. Within the last 5 years has the proposed insured been diagnaged with any of the conditional told by a medical									
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the second seco									
conditions:						Yes	No		
A. A heart attack or stroke?									
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?									
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?									
D. HIV Infection or AIDS?									
E. Diabetes, Hepatitis C or Cirrhosis of the liver?									
F. Alcohol or drug abuse or dependency?									
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?									

## AGREEMENTS AND AUTHORIZATION

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that: (1) This request will be a part of the policy that provides the insurance.

- Inis request will be a part of the policy that provides t
  I may peed to provide more medical info
- (2) I may need to provide more medical info.
- (3) I must report any change in my health that happens before the insurance is effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

\*For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.

*Caution*: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Sign Here	Employee's Signature	Month/Day/Year	Spouse's Signature*	Month/Day/Year
			(If applying for insurance for your spou	use)

*Notice:* Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.