EVIDENCE OF INSURABILITY FORM FOR DISABILITY INSURANCE

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

***Return completed form to*:**
Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-0310
Fax: 800.440.0856

Important: *Please enter all dates in mm/dd/yyyy format.*

EMPLOYER USE (MANDATORY DATA NEEDED): In order for the insurance company to process this form, the employer must complete this information.

EMPLOYER Central Peninsula Hospital **POLICY #** FLK-960406 **CLASS** _____

OCCUPATION _____ **LOCATION/PAYCODE** _____ **DATE OF HIRE** _____

ANNUAL SALARY _____ **AMOUNT TO BE UNDERWRITTEN** _____ **VERIFIED** _____ **DATE** _____

REASON FOR REQUEST: ❑ **LATE ENTRANT** ❑ **LIFE STATUS CHANGE** ❑ **ONGOING ENROLLMENT EVENT**

Please print (preferably in black ink).

EMPLOYEE INFORMATION

Name (First) _____ (Last) _____ (Middle Initial) _____

Social Security # _____ Employee ID Number _____ Sex ❑ M ❑ F

Address _____ Apt # _____ City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____ Birthdate (Mo/Day/Year) _____

ACCEPTANCE/DECLINATION

In order to confirm your election, you must provide a signature for Life Insurance Company of North America.

Signature _____ Date _____ (Mo/Day/Year)

IMPORTANT
Please complete each section that follows.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you (i.e., the Employee) are applying for Disability Insurance more than 31 days after you are eligible.

Height and Weight Information

Employee	Height	ft	in	Weight	lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through O below,
- told by a medical professional he/she has or may have any of the conditions shown below,
- or been treated by a medical professional for any of the conditions shown in items A through O below?

		Employee Yes	Employee No
A.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑
B.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑
C.	Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑
E.	HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	❑	❑
F.	Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑
G.	Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑
H.	Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑
I.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑
J.	Alcohol or drug abuse or dependency?	❑	❑
K.	Any condition affecting hearing or vision, including any loss of sight or hearing, or dizziness or Vertigo?	❑	❑
L.	Carpal Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury?	❑	❑
M.	Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?	❑	❑
N.	Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandibular Joint (TMJ) Disease?	❑	❑
O.	Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?	❑	❑

Fold and staple to conceal health questions. Return to Cigna Group Insurance. Be sure to make a copy for your own records.

Name _____ **Social Security #** _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION B

Employee

Within the last 5 years has the proposed insured: **Yes** **No**

A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction? ☐ ☐

B. Smoked cigarettes: ☐ ☐

1. For how many years has the proposed insured smoked? _____
2. Approximately how many cigarettes are, or were, smoked on average per day? _____
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?
   Month _____ Year_____

C. Used any controlled or illegal drug or other substance? ☐ ☐

D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams? ☐ ☐

E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture? ☐ ☐

F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above? ☐ ☐

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee	*Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

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.*

♦ ♦ ♦ 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. 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.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be 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 of me 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.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.
I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Sign Here _____ *Employee's Signature* _____ *Month/Day/Year*

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.