

EVIDENCE OF INSURABILITY FORM



Life Insurance Company of North America (LINA)
 a Cigna Company (herein called the Insurance Company)
 For info and customer service call

PO Box 20310
 Lehigh Valley, PA 18003

- The applicant must sign and date this form.
 - This form cannot be considered unless received within 30 days of the date it is dated.
- Important: Please enter all dates in mm/dd/yyyy format.

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.

Employer: _____ Policy: _____
 Class: _____ Location: _____ Date of Hire: _____ Annual Salary: _____ Verified By: _____
 Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) _____

VOLUNTARY COVERAGE	EMPLOYEE AMOUNT	SPOUSE* AMOUNT
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 amount subject to Underwriting		

EMPLOYEE SECTION

Employee Name (first, middle, last) _____ Social Security # _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ ID # _____ Birthdate _____ Gender: M F

COMPLETE IF ELECTING SPOUSE* COVERAGE

I am currently married and my date of marriage is: _____ -or- ~~I currently have an eligible Domestic Partner~~
 Spouse* Name: (first, middle, last) _____ Social Security # _____
 Phone _____ Birthdate _____ Gender: M F

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

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 Weight Information					
Employee	Height	ft.	in.	Weight	lbs.
Spouse*	Height	ft.	in.	Weight	lbs.

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

	Employee		Spouse*	
	Yes	No	Yes	No
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 conditions:				
A. A heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. HIV Infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*With respect to AIDS, answer "No" to this question, unless the proposed Insured was diagnosed or treated by a licensed physician.

Name _____ Social Security # _____

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.
- (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.*~~

NOTE: This authorization EXCLUDES the release of any information about previously administered tests for AIDS.

Caution: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.



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

(If applying for insurance for your spouse)

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.