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 1-866-607-2360

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.

Return form to: Cigna address above, Fax 1-800-440-0856, Email: bethlehemmail@cigna.com

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

Employer: Ortonville Area Health Services Policy: SGM611453

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*	
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:	Yes	No	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?	❑	❑	❑	❑

Name _____ Social Security #_____

AGREEMENTS AND AUTHORIZATION

To the best of my knowledge all written, telephonic and electronic information 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), Veterans Administration 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 or my children 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 shall be valid for a period of 26 months from the date signed, and a photographic copy shall be as valid as the original. This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as result of performing emergency medical services.) **The term bloodborne pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to Hepatitis B virus (HBV), the Hepatitis C virus (HCV) and the Human Immunodeficiency (HIV) virus. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

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.)

**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: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Sign Here _____ *Employee's Signature* _____ *Month/Day/Year* _____ *Spouse's Signature** *(If applying for insurance for your spouse)* _____ *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.