

MEDICAL LIFE INSURANCE COMPANY

EVIDENCE OF INSURABILITY

PART I: TYPE OR COMPLETE IN BLACK BALL POINT PEN – PLEASE PRINT	FOR MLI USE ONLY
This application is for a(n): <input type="checkbox"/> New Group <input type="checkbox"/> Addition to Existing Group <input type="checkbox"/> _____ Group Name and Address Completed By _____ Print Name & Title Telephone _____ Group Number _____ Waiting Period _____	Evidence Required Because: <input type="checkbox"/> Over Guaranteed Issue Amt. for <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp. Life <input type="checkbox"/> LTD <input type="checkbox"/> STD <input type="checkbox"/> Other _____ Guaranteed Issue Amt. \$ _____ <input type="checkbox"/> Late Enrollment (contributory only) <input type="checkbox"/> Optional Life: Amt. \$ _____ PLEASE COMPLETE BELOW: <input type="checkbox"/> Total Life Amt. \$ _____ <input type="checkbox"/> Total AD&D Amt. \$ _____ <input type="checkbox"/> Total Supp. Life Amt. \$ _____ <input type="checkbox"/> Total STD Amt. \$ _____ <input type="checkbox"/> Total Dep. Life Amt. \$ _____ <input type="checkbox"/> Total LTD Amt. \$ _____ <input type="checkbox"/> Other \$ _____
	EMPLOYEE <input type="checkbox"/> Approved <input type="checkbox"/> Declined Eff. Date _____ <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker SPOUSE <input type="checkbox"/> Approved <input type="checkbox"/> Declined Eff. Date _____ <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker CHILD (REN) <input type="checkbox"/> Approved <input type="checkbox"/> Declined Eff. Date _____ <input type="checkbox"/> CANCELLED Reviewed by _____ Date _____ State Code _____ Agency _____ <input type="checkbox"/> Self-Admin <input type="checkbox"/> Direct Bill

PART II: TO BE COMPLETED BY EMPLOYEE				
EMPLOYEE NAME (Last, First, Initial)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	S.S. #:	POSITION /BASE ANNUAL EARNINGS	
HOME ADDRESS	DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.	WEIGHT
SPOUSE NAME (If Applying For Dependent Coverage) (Last, First, Initial)	DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.	WEIGHT
UNMARRIED DEPENDENT CHILDREN (Give first name(s) & date(s) of birth.)				

PART III: INSURABILITY QUESTIONNAIRE — Underline condition & record details in PART IV.					
Have you or any of your dependents named above ever had, been counselled or treated for, or been told by a member of the medical profession that you (or they) had:				YES	NO
1. Chest Pain, Heart Murmur, High Blood Pressure, Heart Attack; any disease of the heart or blood vessels? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Diabetes, Thyroid Disorder, Albumin, Blood or Sugar in Urine, or any Kidney Disorder or Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. Tumor, Cyst or Cancer, any Blood Disease or Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO 4. Asthma, Shortness of Breath, Lung or Respiratory Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. Disease or Disorder of the Stomach, Intestines, or Liver? <input type="checkbox"/> YES <input type="checkbox"/> NO 6. Back, Spine or Bone Disease or Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO 7. Seizures, Fainting Spells, Paralysis, Stroke or any Mental or Nervous System Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO Have you or any of your dependents: 8. Within the past 5 years been diagnosed by or received treatment from a medical practitioner for AIDS, AIDS Related Complex, HIV positive status or any other immunological disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO	9. Within the past 5 years, consulted or been attended by a doctor, psychiatrist, or medical practitioner for any health reason not disclosed in the preceding questions? <input type="checkbox"/> YES <input type="checkbox"/> NO 10. Ever had or been told by a medical practitioner that you or they had (or still have) a problem with alcohol or drug abuse? <input type="checkbox"/> YES <input type="checkbox"/> NO 11. Within the past 3 years, had a driver's license restricted, suspended, revoked, or been convicted of drunk driving? <input type="checkbox"/> YES <input type="checkbox"/> NO 12. Been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO 13. Used cigarettes and/or other tobacco products within the last two years? <input type="checkbox"/> YES <input type="checkbox"/> NO 14. Are you or any of your dependents presently receiving any treatment by a medical practitioner or currently taking any medication? <input type="checkbox"/> YES <input type="checkbox"/> NO				

PART IV: Provide details of all 'YES' answers given to questions in PART III. – If additional space is required, attach a separate signed and dated sheet.			
Question Number & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name & Complete Address of Attending Physician or Other Practitioner

AGREEMENTS & AUTHORIZATION: I have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand that Medical Life Insurance Company shall not be liable for any claim on account of death or disability occurring or arising prior to the date of approval of this application at the Home Office of the Company. In order for Medical Life Insurance Company to determine my eligibility for life and/or disability insurance for which I have applied, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health, or that of my spouse or my children, to give the Medical Life Insurance Company or its reinsurers any such information. Such information may include details about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases. This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a Disclosure Statement, and understand that coverage will not become effective until date of approval, provided I am actively at work on that day.

If your answers on this application are incorrect or untrue, Medical Life Insurance Company has the right to deny benefits or rescind your coverage.

Dated at _____, on _____
(CITY, STATE) (MONTH, DAY, YEAR)

Signature of Employee _____ Spouse (if applicable) _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (ORC Section 3999.21) (not enforceable in Oregon or Virginia)

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