

# Evidence of Insurability Form

**Anthem Life**  
**Anthem Life & Disability Insurance Company**  
 P.O. Box 182361  
 Columbus, OH 43218-2361  
 800-551-7265 • 614-433-8880 Fax

Group #

## PART A - GENERAL INFORMATION

Please print in ink or type.

Last Name	First Name	Middle Initial	State of Birth	Date of Birth	Social Security Number
Name of Employer			Height	Weight	Work Phone #

## PART B – DEPENDENT INFORMATION

Complete for all dependents (if any) to be covered under this program.

First Name	MI	Last Name (If different from Employee)	Height	Weight	Birth Date Mo., Day, Yr.	State Of Birth	Gender M or F	Relationship	Full-time Student Y or N	Eligible Income Tax Exemption Y or N
								SPOUSE		

## PART C – MEDICAL QUESTIONNAIRE

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, clergy, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program. To the best of the applicant's knowledge and belief:

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| <p>1. Are you or any of your dependents currently pregnant?<br/>         If yes, who? _____<br/>         Expected due date: _____</p> <p>2. Do you or any of your dependents smoke or use tobacco?<br/>         If yes, who? _____<br/>         Type? _____</p> <p>3. In the past 10 years, has anyone ever:</p> <p style="margin-left: 20px;">a. had high blood pressure or high cholesterol? If yes, last three readings: _____</p> <p style="margin-left: 20px;">b. had heart disease, cancer, diabetes, arthritis, or asthma?</p> <p style="margin-left: 20px;">c. had counseling by a medical or social practitioner for an emotional, mental or nervous condition?</p> <p style="margin-left: 20px;">d. been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated?</p> | <input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO | <p>4. Has anyone ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?<br/>         (You are not required to disclose whether you have been tested or tested positive for HIV)</p> <p>5. In the past three years has anyone been prescribed medication?</p> <p>6. In the past 10 years has anyone had an inpatient admission and/or outpatient surgery?</p> <p>7. During the past three years, has anyone sought medical treatment, or been advised by a medical or social practitioner to seek treatment for any condition not indicated by your answers to the preceding six questions?</p> <p>8. Has anyone ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance?<br/>         If yes, name of person, date and reason:<br/>         _____<br/>         _____</p> <p>9. In the past three years, has anyone been engaged in or does anyone contemplate being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? (Please list)<br/>         _____<br/>         _____</p> | <input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO |
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**IMPORTANT NOTICE:** No person, including an employee or agent of Anthem Life & Disability Insurance Company (Anthem Life) has the authority to change or omit any of these medical questions.

If you answered yes to any questions 3 through 7, provide details below. If additional space is needed, please attach a separate page including your signature and date.

QUEST NO.	NAME OF INDIVIDUAL	NAME OF ILLNESS OR INJURY	DATES OF TREATMENT	ANY REMAINING EFFECTS	NAME OF MEDICATION AND DOSAGE	NAME AND ADDRESS OF PHYSICIAN/HOSPITAL

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**AGREEMENT AND AUTHORIZATION**

I understand that, in order for Anthem Life & Disability Insurance Company (Anthem Life) to accept or decline this application, all of the information requested on the application must be completed. I understand that this application will be attached to and made part of the certificate of coverage. I realize that Anthem Life reserves the right to accept or decline this application (or to accept only certain persons for coverage) and that no right whatsoever is created by this application.

**Authorization to release information:**

I/We authorize any of the entities listed herein to give Anthem Life, and through it, to its affiliates and any administrators, reinsurers, agents, or other entities providing services on behalf of Anthem Life, and to the Medical Information Bureau any data or records in the entities possession about me (or any dependents listed herein), and my mental or physical health (or that of any dependents listed herein), except drug and alcohol treatment information.

This authorization is for: any medical practitioner; hospital; clinic or other medically related facility or provider of health services; insurance company; the Medical Information Bureau; or any other organization, institution, or person that has data on me or my health. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person(s) who signs this form may have a copy of it upon request).

The information gathered will be used for purposes which include: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. I/We understand that Anthem Life may furnish this information to the group or its representative. Anthem Life may also furnish information to other entities, which may include but is not limited to third party administrators, insurers, and government agencies. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, reproductive health, information relating to AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I/We have received and read a copy of Anthem Life's notices about 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices Anthem Life is authorized to obtain an Investigative Consumer report on me. I/We understand that I/We may ask to be interviewed for this report. I/We understand that an Investigative Consumer report may be made. I/We hereby authorize such a report.

I/We also understand that I/We have a right to see and correct personal information that Anthem Life collects about me, and that I/We may receive a more detailed description of my rights under this law by writing to Anthem Life. This authorization will be valid from the date signed for a period of twenty four months. I may revoke this authorization at any time by sending a written request to the Insurer.

I certify that I have read, or have had read to me, the completed application and that all information is true and complete to the best of my knowledge. I understand that any material misrepresentation or significant omission may result in an otherwise valid claim to be denied under any insurance issued from this application.

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SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE (If to be covered)	DATE
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SIGNATURE OF DEPENDENT CHILD (If to be covered and over the age of 14 years, 6 months)	DATE
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This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: Anthem Life, P.O. Box 182361, Columbus, OH, 43218-2361. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

**REFUSAL OF AUTHORIZATION**

I refuse authorization to disclose health care information. I understand that such refusal may result in denial of coverage or denial of a claim.

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SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE (If to be covered)	DATE
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SIGNATURE OF DEPENDENT CHILD (If to be covered and over the age of 14 years, 6 months)	DATE
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**IMPORTANT NOTICE**

The underwriting process is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including statements in the application and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.