120 Royall Street • Canton, MA 02021

1-800-669-2668 Ext. 473



EVIDENCE OF INSURABILITY FORM FOR INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

types of	efer to the Group Policy for pes of coverage available and gible amounts of insurance		PLEASE EMI		IMPORTANT Submit with completed Enrollment form							
Group # Div. #		iv. #	Employer/Group Name									
Social Security #			Employee Name (Last, First, Middle Initial)									
Telephone #			Address									
			PD C		NG INTO	C)						
Name			PROPOSED INSURED(S) Relationship Date of Birth						n Height Weight			
				REAS	ON							
NEW Late Applicant Applying for Coverage in Excess of the Guaranteed Amount Applying for Supplemental Coverage Other					CHANGE ☐ Increase in Coverage ☐ Adding Spouse ☐ Increasing Spouse ☐ Adding Dependent Child(ren) ☐ Other							
			AI	PPLYING	FOR							
<u>YOU</u>			AD	AD&D VC		DLUNTARY LIFE		VOLUNTARY AD&D				
	t Insurance onal Insurance Reques											
	ew Coverage											
	Short Term Disabili	ty \$						_				
	Long Term Disabilit	Weekly Ben			Other		\$					
	SPOUSE	<u>LIFE</u>	<u>AD</u>	<u>0&D</u>	VOLU	<u>UNTAR'</u>	Y LIFE	VOLU	J NTARY AI	<u>D&D</u>		
	t Insurance							_				
	onal Insurance Reques											
Total New Coverage					— — П. С	Other ¢		e ———	œ.			

GRP- EVID - 6/03 220-004 MN 7/03

EVIDENCE OF INSURABILITY

4.4	Please list all life insurance and/or annuity contacts now in-force or pending on your life								
1A. Existing Coverage	Name of Company (if replacement include Policy No.)	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?				
					☐ YES ☐ NO				
					☐ YES ☐ NO				
1B. To be Comp	pleted for ALL Proposed Insured	d(s) if Requi	red by the C	Group Insurance	e Contract				
Have you us 12 months?	**	ts (cigarettes NO	, pipe, cigar	0	cco, nicotine gum or patches) within the past $\mathbf{e} \Box \text{YES} \Box \text{NO}$				
from the o	and and agree that if I have not an certificate effective date, and 2) afte s would have purchased if the ques	r that time, th	e sum payabl	le and every other	erage may be rescinded during the first two years r benefit will be adjusted to the amount which the				
NO PROPOSEI	D INSURED HAS TO DISCLOSE	ANY HIV (A	AIDS VIRUS) TEST WHICH	MAY HAVE BEEN ADMINISTERED.				
2. Have ANY	of the proposed insureds ever be	en diagnosed	d or tested b	y a member of t	he medical profession for:				
or ulcer;		tumor or ma	lignancy; 6)	epilepsy, mental	ise or disorder; 3) intestinal disease or disorder l or nervous disease or disorder; 7) kidney or bints?				
	y of the proposed insureds beer deficiency disorder or AIDS (Ac				mber of the medical profession as having an \square YES \square NO				
	ast 5 years, have any of the prop examination or medical test with				had hospitalization recommended; 2) had a \square YES \square NO				
	or your spouse: 1) fly, or intend glide or sky dive?	d to fly, as p	ilot or crew	member; 2) rac	e or test any form of vehicle; 3) scuba dive;				
					ver received treatment or consultation for the or hallucinogenic drugs or alcoholism?				
	questions 2 - A, B, C, D, E answer				☐ YES ☐ NO				
Name	Disease or Injur	ТУ	Date (s)	Details/Treatment	Names & Address of Attending Phy's & Hospitals				
	REPRESEN	ITATIONS	AND NO	TICE TO APP	LICANTS				
					nplete and true to the best of my/our knowledgonsideration for the insurance applied for.				
Any person wh statement of cla	no knowingly and with intent to nim containing any materially fa	defraud any lse informati	insurance o	company or oth als for the purpo	er person files an application for insurance opse of misleading, information concerning and such person to criminal and civil penalties.				
Signature of Applicant (Employee/Member)					Signed & Dated at (City, State)				
0 11	licant (Other than Employee/Member) the proposed insured is under 15)		Date		Signed & Dated at (City, State)				