



**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.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance

**PLEASE COMPLETE IN FULL**

**IMPORTANT**  
Submit with completed Enrollment form.

**EMPLOYER SECTION**

Group #	Div. #	Employer/Group Name
Social Security #	Employee Name (Last, First, Middle Initial)	
Telephone #	Address	

**PROPOSED INSURED(S)**

Name	Relationship	Date of Birth	Height	Weight

**REASON**

**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 \_\_\_\_\_

**APPLYING FOR . . .**

<u>YOU</u>	<u>LIFE</u>	<u>AD&amp;D</u>	<u>VOLUNTARY LIFE</u>	<u>VOLUNTARY AD&amp;D</u>
Current Insurance	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____
<input type="checkbox"/> Short Term Disability	\$ _____ <i>Weekly Benefit</i>			
<input type="checkbox"/> Long Term Disability	\$ _____ <i>Monthly Benefit</i>		<input type="checkbox"/> Other	\$ _____

<u>YOUR SPOUSE</u>	<u>LIFE</u>	<u>AD&amp;D</u>	<u>VOLUNTARY LIFE</u>	<u>VOLUNTARY AD&amp;D</u>
Current Insurance	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____
			<input type="checkbox"/> Other	\$ _____

