



# Evidence of Insurability Statement for Life and Disability Coverages

## Aetna Life Insurance Company (AUSHC)

Read This Instruction Page Carefully.

### Guidelines

Evidence of Insurability is required if one of the following applies to you:

- You did not request coverage within the eligibility period for your employer’s group Plan of Benefits;
- You have requested reinstatement of coverage which you previously discontinued;
- You are applying for an amount of Life Insurance in excess of your Plan’s non-medical maximum; \*
- You are applying for Long Term Disability or Managed Long Term Disability and you earn \$5,000 or more per month; \* - or -
- You have requested an increase in any coverage. **Please Note:** Additional information will be requested in the following instances:
  - You are applying for more than \$250,000 of additional life insurance; \*
  - You have requested a higher Long Term Disability or Managed Long Term Disability benefit option (if available in your employer’s Plan). \*

\* AUSHC may contact you directly to request additional information upon receipt of this completed Statement.

### Instructions

<p><b>Plan Sponsor</b></p> <p><i>Please Print Firmly</i></p>	<p>Complete Section A. Be sure that:</p> <ul style="list-style-type: none"> <li>• Both the employee’s and your address are shown in the spaces provided.</li> <li>• The employee’s <b>Social Security Number</b> is provided.</li> <li>• Section A is signed by your Authorized Representative.</li> </ul> <p>Give the form to your employee for his/her confidential submission to AUSHC. AUSHC will advise you of its coverage decision.</p>
<p><b>Employee</b></p> <p><b>Read the Privacy Notice and Misrepresentation provision on the back of the Insurability Statement before completing.</b></p> <p><i>Please Print Firmly</i></p>	<p>Verify that your address and <b>Social Security Number</b> as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.</p> <p>Complete Section B. Be sure that:</p> <ul style="list-style-type: none"> <li>• All copies are legible. Please bear down to make clear copies.</li> <li>• All items are completed.</li> <li>• Complete dates and details are given for all “Yes” answers and/or health/dental impairments checked.</li> <li>• Only the names of individuals requesting coverage at this time are listed.</li> <li>• The form is signed by you. If you are requesting spouse coverage, the spouse’s signature is also required.</li> </ul> <p>Keep the last page for your records. Mail <b>all</b> remaining parts to:</p> <p style="padding-left: 40px;">Aetna Life Insurance Company AUSHC Medical Underwriting Department 66 Sigourney Street Hartford, CT 06160-5000 <b>1-800-660-9913</b></p> <p>If a final underwriting decision cannot be made within six months, AUSHC reserves the right to request a new Evidence of Insurability Statement.</p>

**Please Note: If this form is not completed in its entirety and signed, it will be returned unprocessed for your completion.**



**Evidence of Insurability Statement for  
Life and Disability Coverages**  
Aetna Life Insurance Company (AUSHC)

**A. Plan Sponsor: Complete this Section - Please print firmly to make clear copies.**

<b>1. Control Number</b> Suffix                      Account  <b>3. Plan Sponsor's Name &amp; Address</b> ATTN: _____ _____ _____ Street _____ _____ City                                      State                                      ZIP Code	<b>2. Employee's Social Security Number</b> _____ - _____ - _____  <b>4. Employee's Name &amp; Address</b> _____ _____ _____ Street _____ _____ City                                      State                                      ZIP Code
<b>5. Plan Sponsor - Authorized Representative's Telephone Number</b> (       )       -	<b>7. Employee's Telephone Numbers</b> Work (       )       - Home (       )       -
<b>6. Employee's Date of Hire (Month, Day, Year)</b> _____	
<b>8. Applicable for Disability Coverages only:</b> This employee's sick days this calendar year to date are _____; in the last full calendar year the total was _____ (or if worked less than 52 weeks indicate sick days _____ and weeks worked _____).	

**9. Coverage(s) Applied for:**

**Employee Annual Earnings: \$** \_\_\_\_\_ **Employee**                      **Spouse**

**Dependents**

**Life: \***

a. **Current** Amount of Life Insurance Coverage?                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_

b. Amount of Additional Life Insurance Coverage being requested?                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_

c. Resulting (**Total**) Amount of Life Insurance if Requested Amount is Approved (a + b)?                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_

**\*Reason for Requested Coverage:**     Salary Increase     Change in Multiple     Other (Please explain) \_\_\_\_\_

New Employee Requesting an Amount in Excess of the Non-Medical Maximum

**Disability Coverages:**

**Short Term Disability:**    Scheduled Benefit \$ \_\_\_\_\_ or \_\_\_\_\_ %    Benefit Duration in Weeks \_\_\_\_\_

**Long Term Disability:**    Current Monthly Rate of Earnings \$ \_\_\_\_\_

Initial Coverage: Requested Benefit % is \_\_\_\_\_     Higher Plan Option: Present Benefit % is \_\_\_\_\_    Requested Benefit % is \_\_\_\_\_

**Managed Short Term Disability:**    Higher Option Plan: Present Benefit % is \_\_\_\_\_    Requested Benefit % is \_\_\_\_\_

**Managed Long Term Disability:**    Current Monthly Rate of Earnings \$ \_\_\_\_\_

Initial Coverage: Requested Benefit % is \_\_\_\_\_     Higher Plan Option: Present Benefit % is \_\_\_\_\_    Requested Benefit % is \_\_\_\_\_

**10. I certify the above information is correct.**

\_\_\_\_\_

Plan Sponsor - Authorized Representative's Signature                      Plan Sponsor - Authorized Representative's Name (Please print)                      Date Signed

**B. Employee: Complete this Section - Please print firmly to make clear copies.**

**1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed.**

Name	Relationship	Birthdate	Birth Place (City, State)	Sex	Height (ft., in.)	Weight (lbs.)
Employee:	Self	_____	_____	_____	_____	_____
Spouse:	_____	_____	_____	_____	_____	_____
Dependent(s):	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**Complete these questions if dependent children are listed above.** Give dates and details for "No" answers using the space provided in Number 3.

	<b>Yes</b>	<b>No</b>	
a.	<input type="checkbox"/>	<input type="checkbox"/>	Do all dependent children live in your household?
b.	<input type="checkbox"/>	<input type="checkbox"/>	Do all dependent children depend on your household for the majority of their support?
c.	<input type="checkbox"/>	<input type="checkbox"/>	If any dependent child is age 19 or older, is/are they regularly attending school?

**2. Statement of Health for Individual(s) Listed Above.** Give complete dates & details for all health impairments checked using the space provided in Number 3.

	<b>Yes</b>	<b>No</b>	Within the past <b>10 years</b> , has there been any disease/impairment of or treatment for any of the following? If "Yes," check appropriate box(es) below and explain.																																				
a.	<input type="checkbox"/>	<input type="checkbox"/>	<table style="width:100%; border: none;"> <tr> <td style="width:33%;"><input type="checkbox"/> AIDS/AIDS Related Complex *</td> <td style="width:33%;"><input type="checkbox"/> Brain</td> <td style="width:33%;"><input type="checkbox"/> Immune System Disorder</td> <td style="width:33%;"><input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Alcoholism</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Intestines</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Carpal Tunnel Syndrome</td> <td><input type="checkbox"/> Kidney/Bladder</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Liver</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Back/Spine/Neck</td> <td><input type="checkbox"/> Ears/Eyes</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Substance Abuse</td> </tr> <tr> <td><input type="checkbox"/> Blood Pressure/Hypertension</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Mental/Nervous Disorder</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Blood Vessels</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Nervous System</td> <td><input type="checkbox"/> Tumor/Growth</td> </tr> <tr> <td><input type="checkbox"/> Bones</td> <td><input type="checkbox"/> Hernia</td> <td><input type="checkbox"/> Paralysis</td> <td><input type="checkbox"/> Ulcer</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Other (Please Explain) _____</td> </tr> </table>	<input type="checkbox"/> AIDS/AIDS Related Complex *	<input type="checkbox"/> Brain	<input type="checkbox"/> Immune System Disorder	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestines	<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Skin	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver	<input type="checkbox"/> Stroke	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Ears/Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Blood Pressure/Hypertension	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental/Nervous Disorder	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Blood Vessels	<input type="checkbox"/> Heart	<input type="checkbox"/> Nervous System	<input type="checkbox"/> Tumor/Growth	<input type="checkbox"/> Bones	<input type="checkbox"/> Hernia	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Other (Please Explain) _____			
<input type="checkbox"/> AIDS/AIDS Related Complex *	<input type="checkbox"/> Brain	<input type="checkbox"/> Immune System Disorder	<input type="checkbox"/> Rheumatic Fever																																				
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestines	<input type="checkbox"/> Seizures																																				
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Skin																																				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver	<input type="checkbox"/> Stroke																																				
<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Ears/Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Substance Abuse																																				
<input type="checkbox"/> Blood Pressure/Hypertension	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental/Nervous Disorder	<input type="checkbox"/> Thyroid																																				
<input type="checkbox"/> Blood Vessels	<input type="checkbox"/> Heart	<input type="checkbox"/> Nervous System	<input type="checkbox"/> Tumor/Growth																																				
<input type="checkbox"/> Bones	<input type="checkbox"/> Hernia	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Ulcer																																				
<input type="checkbox"/> Other (Please Explain) _____																																							

**Employee: Complete this Section (Continued) - Please print firmly to make clear copies.**

**2. Statement of Health - Continued.** Give complete dates and details for "Yes" answers using the space provided in Number 3.

Yes No

b.   Is any individual pregnant?

c.   Are any inpatient or outpatient medical/surgical or dental procedures or oral surgery (including diagnostic testing) recommended or contemplated?

d.   Is any individual currently taking medication(s) for any condition? If "Yes," list individual(s), medication and dosage, and indicate duration of use and underlying condition.

e.   Does any individual(s) use tobacco products? If "Yes," list individual(s), packs per day and number of years smoked.

Yes No **Within the Past** **Has Any Individual:**

f.   5 Years Been examined by, consulted with, or received medical treatment from any physician, dentist or practitioner for anything other than minor illnesses such as a cold, flu, etc.? If "Yes," please explain.

g.   5 Years Been confined in a hospital, clinic, sanitarium or other treatment facility? If "Yes," please explain.

**3. Use this space to provide the details for "No" answers in Number 1 and "Yes" answers and/or health impairments checked in Number 2.**

Ques. No.	Individual Affected	Diagnosis	Date of Onset	Details/Symptoms	Treatment(s) Received	Full Recovery Date
<input type="checkbox"/> Check here if you are providing additional information on a separate attachment.						

**Certification:** I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform AUSHC of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for group coverage and I acknowledge that I have been given a copy of this document as completed by me.

**Acknowledgment:** I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, misrepresentation provision, and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

**Authorization:** To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage is requested. (Minnesota residents are not required to provide information concerning the results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed (Minnesota residents twelve [12] months). **I acknowledge that I have read the Privacy Notice and Misrepresentation provision shown on the reverse of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

\* AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably, in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

**The employee must sign at all times. The spouse must sign when spouse coverage is requested.**

\_\_\_\_\_  
Employee's or Authorized Person's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Spouse's or Authorized Person's Signature

\_\_\_\_\_  
Date Signed

**C. AUSHC's Acknowledgment to Plan Sponsor**

**APPROVED.** Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_ . If AUSHC is maintaining your records, please submit the appropriate Enrollment/Change form.

**NOT APPROVED** for \_\_\_\_\_ . **Employee has been advised.**

Since the employee's benefits are not approved, dependent coverage will not be issued.

By: \_\_\_\_\_

AUSHC Medical Underwriting

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## Privacy Notice - Insured Plans Only

In evaluating your insurability, we (AUSHC) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on the front of this form.

### Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

### Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company  
AUSHC Medical Underwriting Department  
66 Sigourney Street  
Hartford, CT 06160-5000

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, contact the Member Services number on your ID card, or write to the address shown above.

## Misrepresentation

**Warning:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

**Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**