

EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA)
 a CIGNA Company (herein called the Insurance Company)
 For info and customer service call 1-800-732-1603.



- The applicant must sign and date this form.
 - This form cannot be considered unless received within 30 days of the date it is dated.
- Important:** Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink).

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information.

EMPLOYER Bryn Mawr College Policy FLX-964280

CLASS _____ LOCATION/PAYCODE # _____ DATE OF HIRE _____ ANNUAL SALARY _____ VERIFIED BY _____

REASON FOR REQUEST: NEW HIRE INITIAL ENROLLMENT EVENT ONGOING ENROLLMENT EVENT LATE ENTRANT

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE/DOMESTIC PARTNER
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

EMPLOYEE SECTION

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: M F

In order to confirm your election, please provide your signature: _____ Date _____

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

I am currently married and my date of marriage is _____ -or- I currently have an eligible Domestic Partner

Spouse/Domestic Partner (First) _____ (Last) _____ Social Security # _____

Birthdate _____ Sex: M F

IMPORTANT
 Please complete each section that follows if it is needed.
 Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse/domestic partner information in this section if you (i.e., the Employee) or your spouse are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee				Spouse/Domestic Partner			
Height	ft	in	Weight lbs	Height	ft	in	Weight lbs

PHYSICIAN SECTION

Employee Physician Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse/Domestic Partner Physician Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Height and Weight Information

Employee				Spouse/Domestic Partner			
Height	ft	in	Weight lbs	Height	ft	in	Weight lbs

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

	Employee		Spouse/ Dom. Part.	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fold and staple to conceal health questions. Return application to your employer. Be sure to make a copy for your own records.

