



EVIDENCE OF INSURABILITY FORM FOR GROUP 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

EMPLOYEE/EMPLOYER

Submit with completed Enrollment form.

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 (if pregnant, pre-pregnancy 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 _____

INSURANCE

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

