# EMPLOYEE MEDICAL EVIDENCE OF INSURABILITY & APPLICATION

**Application to Guarantee Trust Life Insurance Company, Glenview, IL**

**May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.**

## SECTION 1 – APPLICANT INFORMATION

| FULL NAME OF EMPLOYEE | MARITAL STATUS | SEX | HEIGHT | WEIGHT |
|---|---|---|---|---|
| | | | | |

| RESIDENCE ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER (include area code) | Best time to contact ( if additional information is required by Insurance Company) |
|---|---|
| | |

| AGE (last Birthday) | BIRTHDATE (mm/dd/yy) | DATE BEGAN FULL TIME (mm/dd/yy) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| EMPLOYED BY | EMPLOYERS PHONE (include area code) | AVG. NO. HOURS WORKED WEEKLY | MONTHLY EARNINGS $ |
|---|---|---|---|
| | | | |

| EMPLOYER'S LOCATION – STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| OCCUPATION AND DUTIES | LIFE INSURANCE BENEFICIARY AND RELATIONSHIP |
|---|---|
| | |

❑ I AM ❑ I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER

I Am Applying for (check one): ❑ SELF ONLY; ❑ SELF AND SPOUSE; ❑ SELF AND CHILD(REN) ❑ SELF, SPOUSE, & CHILD(REN)

I Am Applying for (check all that apply): ❑ ALL BENEFITS ❑ LIFE INSURANCE AND/OR WEEKLY DISABILITY INCOME BENEFITS ONLY

| ADM. Use Only |
|---|
| CASE NO. |
| EMPLOYEE NO. |
| CLASS |
| EFFECTIVE DATE |
| OCC YES ❑ NO ❑ |
| UWF 48 YES ❑ NO ❑ DATE _____ |
| UWF 40 YES ❑ NO ❑ |
| HEALTH YES ❑ NO ❑ |
| ADD LIFE YES ❑ NO ❑ |
| WDI YES ❑ NO ❑ |

If you have dependents (spouse and/or children) and have chosen not to include any dependents in this coverage, please complete the following:
I AM NOT APPLYING FOR DEPENDENT COVERAGE BECAUSE (check one):

❑ Covered by another group/individual health plan. ❑ Other (explain) _____

I understand, that if I have dependents and do not make application at this time, I may be forfeiting certain rights as described on the reverse under Applicant Statement. I understand that I have the right to apply for coverage at this time. I am voluntarily declining dependent coverage and have not been induced or pressured by anyone to decline coverage.

### DEPENDENT INFORMATION

| | NAMES OF DEPENDENTS | RELATIONSHIP | HEIGHT | WEIGHT | DATE OF BIRTH |
|---|---|---|---|---|---|
| **Dependent Information** Complete for spouse and each dependent child to be insured. (use additional sheet if necessary) | | | | | |
| | 1. | | | | |
| | 2. | | | | |
| | 3. | | | | |
| | 4. | | | | |
| | 5. | | | | |

### ADM. USE ONLY

| MUW | MHX | LAT | D&R | PXT |
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## SECTION 2 – MEDICAL INFORMATION

1. Has anyone applying within the last 10 years been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection or any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), significant weight loss, chronic fatigue or diarrhea, night sweats or enlarged glands? ❑ YES ❑ NO
2. Are you or any dependent (whether applying for coverage or not) currently pregnant or is anyone applying for coverage Disabled, restricted or unable to perform the normal activities of daily living and self care? ❑ YES ❑ NO
3. During the past 5 years, has anyone applying for coverage had medical consultation, surgery, been hospitalized or Is anyone currently taking medication? ❑ YES ❑ NO
4. Have you or anyone applying for coverage in the past 10 years had a diagnosis of or consultation, treatment or medication for:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Brain or Nervous System | ❑ | ❑ | Thyroid or Pituitary Disorder | ❑ | ❑ |
| Nervous, Mental or Emotional Disorder | ❑ | ❑ | Diabetes or Sugar in Urine | ❑ | ❑ |
| Drug or Alcohol Abuse | ❑ | ❑ | Disease of the Muscles | ❑ | ❑ |
| Epilepsy or Cerebral Palsy | ❑ | ❑ | Bone or Joint Disorder | ❑ | ❑ |
| Abnormal Blood Pressure | ❑ | ❑ | Arthritis, Rheumatism, Bursitis | ❑ | ❑ |
| Heart or Circulatory System | ❑ | ❑ | Disorders of Back or Spine | ❑ | ❑ |
| Chest Pain or Stroke | ❑ | ❑ | Lungs or Respiratory System | ❑ | ❑ |
| Blood Disorder or Varicose Veins | ❑ | ❑ | Emphysema, Tuberculosis, Chronic Obstructive Pulmonary Disease or Asthma | ❑ | ❑ |
| Digestive or Gastrointestinal Tract | ❑ | ❑ | Multiple Sclerosis or Cystic Fibrosis | ❑ | ❑ |
| Cirrhosis or Hepatitis | ❑ | ❑ | Skin or Collagen Disease | ❑ | ❑ |
| Liver, Pancreas or Kidney | ❑ | ❑ | Cancer, Leukemia or Hodgkin's Disease | ❑ | ❑ |
| Rectum, Prostate or Hernia | ❑ | ❑ | Lymphatic Vessels or Glands | ❑ | ❑ |
| Genitourinary System | ❑ | ❑ | Any Physical Deformity or Defect | ❑ | ❑ |
| Breast or Reproductive Organs | ❑ | ❑ | | | |
| Endocrine or Adrenal Disorder | ❑ | ❑ | | | |

Applicant: Please Initial & Date

**Please give details to any yes answer on reverse. Complete information & sign on reverse.**

Use this space to give details to any "YES" answer to questions 1 through 4. Use a separate sheet if additional space is needed; sign & attach additional pages. If taking medication for high blood pressure, please include your last 3 blood pressure readings.

| Question # | Person | Medical Condition or Specific Reason for Treatment | Dates of Treatment | Duration of Illness | Was Recovery Complete? Y/N | Please list any Treatment, Surgery or Medications taken for this condition including dosages and duration. |
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## SECTION 3 – PRIOR INSURANCE COVERAGE CREDIT

Have you or your dependents been covered under any health insurance plan within the last 90 days?.....❑ YES ❑ NO

If Yes, to qualify for prior coverage credit, please provide the following information on all coverage inforce in the past 12 months – Please note that most of this information can be obtained from your current Insurance Identification Card:

Name of Insurance Company_____Ins. Co. Phone Number ( )_____

Effective date of Prior Coverage* _____Termination Date _____

Type of Coverage (i.e. employer sponsored or individual)_____ Policy/Cert. Number_____

Coverage was for (check all that apply): ❑ Myself ❑ Spouse ❑ Children

❖ *We need confirmation of your coverage with your prior carrier. Please provide us with a copy of the Certificate of Credible coverage provided by the carrier.*

## SECTION 4 – APPLICANT STATEMENT & SIGNATURE

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Master Policy issued by the Insurance Company. I authorize my employer to pay premiums and to deduct any required premium contribution from my earnings. I understand that my employer, is being authorized to pay premium, is my agent and not the agent of the Insurance Company, and that my insurance may be terminated if premiums are not paid by my employer as required.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be found guilty of insurance fraud in a court of law. I understand that my coverage, if approved, and that of my eligible dependents, will be subject to the pre-existing condition and replacement of coverage provisions specified in the Master Policy. I understand that, subject to the replacement of coverage provisions of the Master Policy, I may not be eligible for coverage if I am currently totally disabled.

I authorize any physician, medical practitioner, hospital, other medical related facility, insurance company, consumer reporting agency or employer having information available regarding me or my dependents as to employment, other insurance coverage, diagnosis, prognosis, medical treatment or care pertaining to any physical or mental condition including alcohol or drug dependency, to release such information to the Insurance Company or their legal representative, agent or vendor and that I am entitled to a copy of the investigative consumer report. I know that I may request a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid until withdrawn by me in writing.

I understand that if I am not applying for dependent coverage due to reasons other than my dependents having qualifying existing coverage there are two important consequences: The effective date of coverage may be delayed or the period during which pre-existing conditions will not be covered may be extended for my dependents, as described in the Late Applicant Eligibility, Effective Dates and Pre-Existing Conditions Limitations provision set forth in the Master Policy. As a result, I waive all claim benefits payable for my dependents. Further, I understand that in order for my dependents to be covered under this Plan in the future, I may be required to furnish satisfactory evidence of insurability at my expense, and all provisions applicable to a dependent will apply.

**PERSONAL INFORMATION NOTICE**

As required by law, this notice is intended to inform you that 1) Personal information may be collected from persons other than the individual applying for coverage; 2) Such information as well as other personal or privileged information collected by the Insurance Company or its legal representative may be in certain instances, as prescribed by law, disclosed to third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of insurance information practices upon request.

Signature of Employee X _____ Date _____

**RETURN APPLICATION TO ALLIED NATIONAL • UNDERWRITING • P.O. BOX 419254 • KANSAS CITY, MO 64141-6254**