

EVIDENCE OF INSURABILITY FORM

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.

Return completed form in the envelope provided to
 Cigna Group Insurance
 P.O. Box 20310
 Lehigh Valley, PA 18003-9924
 Fax: 800.440.0856



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	Enterprise Electric, LLC	Policy	FLX965978
CLASS	LOCATION/PAYCODE #	DATE OF HIRE	ANNUAL SALARY
REASON FOR REQUEST: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> INITIAL ENROLLMENT EVENT <input type="checkbox"/> ONGOING ENROLLMENT EVENT <input type="checkbox"/> LATE ENTRANT			
	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE	
NEW COVERAGE (TOTAL)			
CURRENT COVERAGE			
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE			
AMOUNT SUBJECT TO MEDICAL EVIDENCE			

EMPLOYEE SECTION

Mr. Mrs. Ms. (Check One)

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 COVERAGE

I am currently married and my date of marriage is _____

Spouse Name (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 info 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			
Height	ft	in	Weight lbs	Height	ft	in	Weight lbs

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

Within the last 5 years has the proposed insured been:

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

	Employee		Spouse	
	Yes	No	Yes	No
A. A heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

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

◆ ◆ ◆ AGREEMENTS AND AUTHORIZATION ◆ ◆ ◆

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I must report any change in my health that happens before the insurance is effective.
- (4) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)



Sign Here

Employee's Signature

Month/Day/Year

Spouse's Signature
(If applying for insurance for your spouse)

Month/Day/Year

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Return to your employer. Be sure to make a copy for your own records.