



# The First Rehabilitation Life Insurance Company of America

600 Northern Boulevard, Great Neck, New York 11021-5202  
(516) 829-8100(800) 365-4999 Fax: (516) 829-8211  
www.firstrehab.com

## Group Long Term Disability Insurance Policy Evidence of Insurability

1. Policy Number:		2. Division No.		3. Policyholder's Name:	
4. Employee's Last Name: First Middle Initial			5. Social Security Number: _____		
6. Birth date (mm/dd/yyyy): _ _ / _ _ / _ _ _ _	7. Employment Date (mm/dd/yyyy): _ _ / _ _ / _ _ _ _	8. Sex <input type="checkbox"/> F <input type="checkbox"/> M	9. Salary: \$ _____ per week/month/year (circle applicable schedule)	10. Hours Worked Per Week:	
11. Occupation/Title:		12. Check to enroll for Group Long Term Disability coverage: <input type="checkbox"/> Yes, I wish to enroll for coverage <input type="checkbox"/> No, I wish to decline coverage			
8. Beneficiary: Last Name First Middle Initial			13. Relationship of Beneficiary to Employee:		
14. Full Name and Address of Your Physician:		16. Height and Weight:	15. Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No		

To the best of your knowledge and belief, in the past five years have you:

	Yes	No
1. Consulted or been examined by a physician, practitioner or specialist, other than for routine annual physicals?		
2. Been medically treated or medically diagnosed for any of the following: epilepsy, paralysis, or any nervous, mental or emotional disorder?		
3. Been medically treated or medically diagnosed for any of the following: abnormal blood pressures, heart attack, heart murmur, stroke, any other blood, heart, or circulatory disorder?		
4. Been medically treated or medically diagnosed for any lung or respiratory disorder?		
5. Been medically treated or medically diagnosed for ulcer of the stomach or duodenum, any rectal, liver or gall bladder disorder, or any other digestive disorder?		
6. Been medically treated or medically diagnosed for kidney or any urinary disorder, albumin, pus or sugar in urine, disorder of the prostate or genital organs?		
7. Been medically treated or medically diagnosed for thyroid disorder, diabetes, gout, any eye or ear disorder, any discolored areas or lesions of the skin or mouth?		
8. Been medically treated or medically diagnosed for arthritis, rheumatism, any disorder of the back, spine, bones, muscles or joints?		
9. Been medically treated or medically diagnosed for cancer, tumor, growth, enlarged lymph nodes or any skin disorder?		
10. Been medically treated or medically diagnosed for alcoholism, drug dependency or substance abuse?		
11. Been medically treated or medically diagnosed for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?		

For each question 1 through 11 for which you answered yes, complete the following. (If additional space is needed, use a signed, dated separate sheet.)

Question #	Medical Condition	Dates	Results	Doctor or Hospital Name & Address

If you answered "Yes" to any question 1 through 11, describe how your condition or impairment limits or affects your ability to perform the tasks of your occupation?

I agree that the statements and answers contained in this Evidence of Insurability form are complete and true. I authorize any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance or reinsuring company, medical information bureau, employer or the Veterans Administration, having information available as to advice, diagnosis, treatment or care of any physical or mental condition concerning me, including information about drugs, alcoholism or mental illness, and or any other non-medical information concerning me, to give any and all such information to THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA, its legal representative or its reinsurers.

I understand the information obtained by use of this Authorization will be used by THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA to determine eligibility for insurance. I may request a copy of this form. I agree that a copy of this form shall be as valid as the original. I agree that this form shall remain valid for two years from the date shown below.

**NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

Dated \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Name of Applicant (please print) \_\_\_\_\_