



# Evidence of Insurability

GE Group Life Assurance Company  
100 Bright Meadow Boulevard  
Enfield, CT 06082

### Answer all Questions Completely - Please Print Legibly

Name of Employee	Occupation	Name of Employer	Group Policy Number
Residence (No., Street, City, State, ZIP Code)		Employer's Address (No., Street, City, State, ZIP Code)	
Home Phone Number		Work Number Where You May Be Reached	

#### Reason for Evidence of Insurability

Class Change     
  Late Applicant     
  Late Dependent coverage     
  Adding New Dependent     
  Amount over Non-Med Issue  
 Adding different line of coverage / What coverage \_\_\_\_\_
  Medical coverage requiring Evidence of Insurability\*\*

\*\*You will not be declined for medical coverage based on your health.

Salary Increase / New Salary \_\_\_\_\_
  Year   
  Month   
  Week   
  Hourly \_\_\_\_\_ number of hours

Applicants for Long Term Disability Coverage: Do you currently have or are you applying for other Disability Income Insurance?  Yes  No  
 If "Yes", please provide us with the information below.

Insurance Company	Effective Date of Coverage	Monthly Amount	Maximum Benefit Period	Elimination Period	Will the Insurance being applied for replace this coverage?		Replacement Date
					Yes	No	

#### Names of Employee and all Family Members Requesting Coverage & for Whom Evidence is Required

Name	Sex	Relationship	Date of Birth	Height	Weight	Social Security Number
		Self				

NOTE: PLEASE BE SURE TO ANSWER ALL QUESTIONS. COMPLETENESS HELPS SPEED PROCESSING. INCLUDE DOCTOR'S FULL NAME, OFFICE ADDRESS AND PHONE NUMBER INCLUDING ZIP AND AREA CODES IF POSSIBLE. IF MORE SPACE IS REQUIRED ATTACH ADDITIONAL SHEET. FAILURE TO PROVIDE COMPLETE RESPONSES MAY RESULT IN UNDERWRITING DELAYS, RESCISSION OF COVERAGE AND/OR NON-PAYMENT OF CLAIM. THIS REQUEST FOR COVERAGE IS NOT EFFECTIVE UNTIL APPROVED BY GE GROUP LIFE ASSURANCE COMPANY. NO INFORMATION PROVIDED BY YOU TO YOUR AGENT SHALL BIND GE GROUP LIFE ASSURANCE COMPANY UNLESS YOU ALSO PROVIDE SUCH INFORMATION IN WRITING ON THIS FORM. NO AGENT OR BROKER HAS THE AUTHORITY TO ALTER THE CONTENTS OF THIS FORM.

YES NO For questions 1-8: Within the past 5 years

- Have you or any of your dependents ever had or been told that you/they had elevated blood pressure, chest pain, heart murmur, circulatory or other heart disorder; blood, pus or sugar in the urine, diabetes, kidney, liver or bladder disorder, ob/gyn disorder including diagnosis or treatment for infertility, any sexually transmitted disease or disorder, blood disorder, immunological disease or disorder, cancer or tumor, ulcer or other gastrointestinal disorder, disorder of the neck, back or knees, epilepsy or severe headache, asthma or respiratory disorder, mental, emotional or nervous disorder, alcoholism, chemical dependency or substance use, abuse and/or dependency?
- Have you or any dependents been diagnosed as having AIDS-related complex (ARC) or acquired immune deficiency syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?
- Have you or any dependents experienced unexplained persistent diarrhea, unexplained unintentional weight loss, night sweats or persistent swollen glands?
- Have you or any dependents ever used narcotics, barbiturates, amphetamines, hallucinogens, or other drugs except as prescribed by a physician?
- Have you or any of your dependents been hospitalized, had surgery, taken medication regularly or at frequent intervals or been treated by a physical or psychological health care practitioner including routine examinations?
- Have you or any dependents ever been a patient in a hospital, sanatorium or other medical facility for rest, observation, diagnosis, treatment or for a surgical operation?
- Have you or any dependents ever had Life, Accident, or health insurance or reinstatement of such insurance, declined, postponed, rated, ridered or modified?
- Have you or your dependents had any benefits paid under another GE Group Life Assurance Company plan?  
If yes, please provide the account number(s) \_\_\_\_\_.
- Are you or any of your dependents currently pregnant? If yes, give due date \_\_\_\_\_.
- Have you or your dependents used any type of tobacco products in the past 36 months?
- Have you or your dependents ever been told or had reason to believe that medical, surgical, psychiatric or rehabilitative care may be required during the next 12 months?

Please Complete Both Sides Of This Form

**Give Details Below For All Questions Answered "Yes"**

Question Number	Nature of Ailment	Date of Onset, Duration and Degree of Recovery	Name and Address of Physician, Practitioner, Hospital or Institution

**Do Not Detach - Please Complete Authorization To Release Information**

I certify that all information shown above is correct and I have read this form.

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health or my dependents or their health history to give any such information to GE Group Life Assurance Company and its legal representatives: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person, any employer, group policyholder or certificateholder.

I understand that the information released to GE Group Life Assurance Company will be used to determine my eligibility for the insurance requested. GE Group Life Assurance Company may redisclose such information for that purpose to the employer or union connected with the group insurance coverage involved herein, the group policyholder or certificateholder, or their representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of GE Group Life Assurance Company. The information may also be redisclosed as otherwise specifically permitted or required by law.

This authorization extends to and includes HIV-related information, AIDS or AIDS-related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. This authorization or photocopies of it will be valid for two and one-half years following the date signed, unless otherwise required by law. The information released to GE Group Life Assurance Company will not be given, sold or transferred to any other person or entity not mentioned above.

I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee

Date

**IMPORTANT NOTICE**

Information regarding your insurability will be treated as confidential. GE Group Life Assurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance, or submit a claim for benefits to such a company, the Bureau, upon request, will supply such company with the information it may have.

GE Group Life Assurance Company or its reinsurers may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The Company will not, however, reveal to another company or to the Bureau the action taken on the basis of your current request for insurance.

Upon request, the Bureau will arrange disclosure of information in your file. (Non-medical information will be disclosed to you and medical information will be disclosed to your attending physician.) If you question the accuracy of the information, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's information office is at P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone 617-426-3660.

**NOTICE**

Personal information may be collected from persons other than the individual or individuals proposed for coverage.

Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization.

You have the right to see your personal records and correct personal information collected.

You will be furnished our detailed Description of Information Practices form (ESG GL 1607) upon request from either the firm administrator and/or the Main Administrative Office.

**FRAUDULENT INSURANCE ACT**

Any person knowingly and with intent to defraud any insurance company or other person, either:

- 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 material fact, commits a fraudulent insurance act, which is a crime. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES. In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**CALIFORNIA NOTICE**

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.