



# Evidence of Insurability

**FOR COMPANY USE ONLY**  
 APPROVED: \_\_\_\_\_  
 DATE: \_\_\_\_\_

Evidence required because of:  
 Over Guaranteed Issue Amount  
 Late Enrollment

This applicant is:  
 New Group  
 Addition to Existing Group  
 Change of Benefits

Group No.: \_\_\_\_\_  
 Application is made for:  
 Basic Life Amount: \_\_\_\_\_  
 Supplemental Life Amount: \_\_\_\_\_  
 Dependent Life Amount: \_\_\_\_\_  
 Other: \_\_\_\_\_

NAME OF APPLICANT				IF DEPENDENT, RELATIONSHIP TO EMPLOYEE			
ADDRESS		STREET		CITY		STATE	
ZIP CODE		PHONE NUMBER		( )			
DATE OF BIRTH		PLACE OF BIRTH		SOCIAL SECURITY NO.		SEX	
YOUR OCCUPATION				EMPLOYER'S NAME			
HEIGHT		WEIGHT		HAVE YOU GAINED OR LOST MORE THAN 20 POUNDS IN THE LAST YEAR?		GIVE DETAILS BELOW.	
				<input type="checkbox"/> YES - IF SO <input type="checkbox"/> NO		<input type="checkbox"/> GAINED <input type="checkbox"/> LOST _____ POUNDS	
FULL NAME OF YOUR REGULAR PHYSICIAN							
FULL STREET ADDRESS OF YOUR REGULAR PHYSICIAN		STREET		CITY		STATE	
						ZIP CODE	
DATE AND REASON LAST CONSULTED							

- If employed, are you actively at work at least 20 hours a week?  YES  NO
- During the last five years, have you been absent from work more than five consecutive working days because of illness or injury? If "YES", give details below.  YES  NO
- Are you now under regular medical observation or taking medical treatment? If "YES", give details below.  YES  NO
- Within the last five years, have you consulted a physician for any disease or injury, or have you been advised to have any surgical operation or diagnostic tests? If "YES", give details below.  YES  NO
- To the best of your knowledge have you had or been told you had an Immune Deficient Disorder (AIDS), or the AIDS Related Complex (ARC), or test results indicating exposure to the AIDS Virus?  YES  NO
- Please check either "YES" or "NO" if you ever had or have been told that you had any of the following. If "YES", give details below.

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or Albumin or Sugar in the Urine	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Disorder of the Stomach or Intestines or Liver	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis or Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>			

CONDITION	DATE	REMAINING EFFECTS	PHYSICIAN'S FULL NAME AND ADDRESS

I have read the answers and statements on this application and agree that the above answers are complete and true to the best of my knowledge and belief. I acknowledge receipt and understanding of "Notice of Exchange of Information" explained below. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give Anthem Blue Cross Life and Health Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

\_\_\_\_\_  
 SIGNATURE OF APPLICANT DATE

CUT OFF - FOR APPLICANT'S REFERENCE

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**NOTICE OF EXCHANGE OF INFORMATION**

Thank you for enrolling for Group Insurance with Anthem Blue Cross Life and Health Insurance Company. As part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability. Information regarding your insurability will be treated as confidential. Anthem Blue Cross Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit 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 coverage or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

You must complete this Evidence of Insurability form because:

1. You applied for coverage more than 31 days after you were first eligible to apply

or

2. You are requesting an amount in excess of the guaranteed issue amount of coverage

Submission of an Evidence of Insurability form is not a guarantee of coverage. Upon completion of the review process you will be notified of the acceptance or rejection of coverage.

The review process may involve a paramedical exam that will include diagnostic procedure, including the drawing of blood for lab testing. You will be contacted by a representative from our paramedical examier, if an exam is required. The cost of this exam is paid for by Anthem Blue Cross Life and Health Insurance Company.

Please mail completed form to:  
Anthem Blue Cross  
Medical Evidence Underwriting Unit  
PO Box 4510  
Woodland Hills, CA 91365-4510  
Phone: 800-713-6274  
FAX: 818-234-6559