Evidence of Insurability Form

for initial enrollment and late enrollees

ADVANCE Insurance Company of Kansas℠

I want to enroll in: ☐ Basic Term Life ☐ Optional Life ☐ Long Term Disability
☐ Basic Dependent Life ☐ Short Term Disability ☐ Voluntary Long Term Disability

Section 1 – Applicant Information

CLEAR DATA

Always complete this section, answer the medical questions (Sections 4 and 5), and sign and date the authorization (Section 6).

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Date of Birth ____ /____ /____

Social Security Number ____-____-____

Height _____ Weight _____

Employer Name _____

Employer City _____ Work Phone Number (____) ____-____

Occupation/Job Title _____ $ Hourly Wage _____

Date of Hire ____ /____ /____ Date of Employment Change ____ /____ /____

Reason for employment change:
☐ Part-time to full-time ☐ Temporary to permanent
☐ Rehire/recall ☐ Other _____

Are you actively at work performing all of your job duties? ☐ Yes ☐ No

I am working _____ hours weekly for this employer.

Physician Name _____

Physician Address/P.O. Box _____

City _____

State _____ ZIP Code _____ +4 _____

Section 2 – Beneficiary Information

The **primary beneficiary** receives your death benefit. If naming two or more beneficiaries, proceeds will be paid in equal shares unless stated otherwise. If listing a minor, proceeds will be paid to a conservator appointed by the court system for the child. **If space is inadequate for your beneficiaries, attach a separate signed and dated list providing complete information.**

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth ____ /____ /____

City _____ State _____

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth ____ /____ /____

City _____ State _____

The **contingent beneficiary** receives your death benefit **only if** the primary beneficiary(ies) is/are deceased.

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth ____ /____ /____

City _____ State _____

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth ____ /____ /____

City _____ State _____

Please continue on the next page.

Section 3 – Spouse and Dependent Information

Spouse information:

First Name ______ MI ______ Physician Name ______

Last Name ______ Suffix ______ Physician Address/P.O. Box ______

Gender ☐ Male ☐ Female ____ /____ /____ Date of Birth ______ City ______

____-____-______ Social Security Number ______ Height ______ Weight ______ State ______ ZIP Code ______ +4 ______

Spouse's Employer ______

Child information

First Name ______ MI ______ Physician Name ______

Last Name ______ Suffix ______ Physician Address/P.O. Box ______

Gender ☐ Male ☐ Female ____ /____ /____ Date of Birth ______ City ______

Relation to Applicant ______ Height ______ Weight ______ State ______ ZIP Code ______ +4 ______

Child information

First Name ______ MI ______ Physician Name ______

Last Name ______ Suffix ______ Physician Address/P.O. Box ______

Gender ☐ Male ☐ Female ____ /____ /____ Date of Birth ______ City ______

Relation to Applicant ______ Height ______ Weight ______ State ______ ZIP Code ______ +4 ______

Child information

First Name ______ MI ______ Physician Name ______

Last Name ______ Suffix ______ Physician Address/P.O. Box ______

Gender ☐ Male ☐ Female ____ /____ /____ Date of Birth ______ City ______

Relation to Applicant ______ Height ______ Weight ______ State ______ ZIP Code ______ +4 ______

Child information

First Name ______ MI ______ Physician Name ______

Last Name ______ Suffix ______ Physician Address/P.O. Box ______

Gender ☐ Male ☐ Female ____ /____ /____ Date of Birth ______ City ______

Relation to Applicant ______ Height ______ Weight ______ State ______ ZIP Code ______ +4 ______

Please continue on the next page.

Section 4 – Medical History

Please answer all the medical questions below as they would apply to any eligible person that is requesting coverage.

Has anyone been diagnosed, treated for, receiving treatment by a medical professional or had any of the following conditions? (If any responses are answered "Yes", provide details in Section 5.)

	Employee	Spouse	Child(ren)
1. Heart or artery disorder, heart murmur or heart attack, tuberculosis, liver, stomach or intestine disorder, kidney disorder, asthma, lung or other respiratory disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. High blood pressure? If yes, give last two readings and dates:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Diabetes, albumin, blood or sugar in the urine? If diabetic, give age of onset and how controlled.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Cancer, leukemia, malignant growth or any form of tumor?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Epilepsy or any mental or nervious system disorder, alcoholism, drug or substance abuse?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Any disorder of the immune system, including AIDS, (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or HIV infection?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Back, spine or bone disease or disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. In the last five years, have you or anyone requesting coverage been seen by any type of a medical (or mental health) doctor orpractitioner for any reason or condition other than those listed in questions 1-7?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. Is anyone presently pregnant? If yes, provide expected date of delivery:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. Is anyone presently under observation or receiving medical treatment? Presently taking medication? If yes, provide the name of the condition, name of the medication, dosage and frequency.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
11. In the last five years, has anyone requesting coverage ever been rated, declined, postponed or limited in any way for life, disability, health or accident insurance?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Please continue on the next page.

Section 5 – Medical Details

For any "Yes" response in Section 4, explain conditions in detail below. If incomplete, this form will be returned to you, causing a delay in the application process. If additional space is required for a complete response, please attach a separate signed and dated sheet providing the details.

Question # ______ Enrollee's Name ______ Treatment Provided By ______

Nature of Condition ______ Provider's Address/P.O. Box ______

Medication Prescribed (Name, Dosage, Frequency) ______ City ______

___ / ___ / ___ Date Diagnosed ___ / ___ / ___ Date Last Seen for Condition ______ State ______ ZIP Code ______ +4

Degree of Recovery ______

Question # ______ Enrollee's Name ______ Treatment Provided By ______

Nature of Condition ______ Provider's Address/P.O. Box ______

Medication Prescribed (Name, Dosage, Frequency) ______ City ______

___ / ___ / ___ Date Diagnosed ___ / ___ / ___ Date Last Seen for Condition ______ State ______ ZIP Code ______ +4

Degree of Recovery ______

Question # ______ Enrollee's Name ______ Treatment Provided By ______

Nature of Condition ______ Provider's Address/P.O. Box ______

Medication Prescribed (Name, Dosage, Frequency) ______ City ______

___ / ___ / ___ Date Diagnosed ___ / ___ / ___ Date Last Seen for Condition ______ State ______ ZIP Code ______ +4

Degree of Recovery ______

Question # ______ Enrollee's Name ______ Treatment Provided By ______

Nature of Condition ______ Provider's Address/P.O. Box ______

Medication Prescribed (Name, Dosage, Frequency) ______ City ______

___ / ___ / ___ Date Diagnosed ___ / ___ / ___ Date Last Seen for Condition ______ State ______ ZIP Code ______ +4

Degree of Recovery ______

Please continue on the next page.

Section 6 – Authorization

The requested insurance will not be effective until approved by Advance Insurance Company of Kansas (AICK).

I understand that my spouse and I must both sign this section if I am requesting coverage for my spouse; and, that my dependents 18 or older must sign this section, as well, if I am requesting coverage for them. The signature(s) verifies that the dates of birth, heights and weights are correct, that the answers to the questions and any statements contained therein are true and complete, and that, every occasion and instance as to each item that should be answered "Yes" in Section 4 has been fully disclosed in Section 5.

My signature authorizes any physician, medical practitioner or provider of medical or dental services or supplies, hospital, clinic, pharmacy or other medically related facility, insurance or reinsurance company, the Medical Information Bureau Inc. (MIB), consumer reporting agency or employer, having information available as to diagnosis, consultation, treatment and prognosis with respect to any physical or mental condition and/or treatment of, and any other non-medical information about, me, my spouse, or my minor children to release and disclose to Advance Insurance Company of Kansas (AICK), or to its reinsurance companies, a complete copy of any and all health information. This information includes, but is not limited to, x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations and treatment notes. For the purposes of this authorization, health information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness but excludes psychotherapy notes as defined by HIPAA.

I understand that the information obtained by use of this authorization will be used by AICK to underwrite the insurance being requested to determine eligibility for insurance; and, that coverage may be delayed or denied if AICK is unable to obtain information necessary to do so.

I understand that information disclosed may no longer be protected and may be re-disclosed without further authorization. Note that AICK will not release information to any person or organization except to reinsurance companies or other persons, or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or further authorized.

I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this authorization or AICK otherwise has the right to contest the policy or claims under the policy.

I know that I, or my authorized representative, may request to receive a copy of this application. I agree that a photographic copy of the authorization shall be as valid as the original. I agree this authorization shall be valid for 24 months from the date shown below. If my answers on this application are incomplete, incorrect, or untrue, AICK has the right to deny benefits or rescind coverage within two years of the policy effective date.

I understand I will be responsible for any fees or cost associated with the physical or for obtaining medical records to prove my insurability as a late enrollee(s) in the insurance program.

I (1) request the coverage for which I am or may become eligible under the group policy or policies issued by AICK; (2) authorize the necessary payroll deductions, if any, from my earnings; (3) designate the beneficiary named on this form to receive the benefits, if any, payable in the event of death; (4) understand that among the requirements for continued eligibility is that I be a full-time active employee working the hours per week required for eligibility as stated in the group policy. I believe that all persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A., and that, to the best of my knowledge, the information which I have provided on this form is true and correct as it pertains to my status with the above employer.

Print Name (Applicant) _____ Date of Birth _____ / _____ / _____

Applicant Address (Street/P.O. Box, City, State, ZIP)

Your signature required

Applicant _____ Date Signed _____ / _____ / _____

Print Name (Spouse) _____ Date of Birth _____ / _____ / _____

Spouse Address (Street/P.O. Box, City, State, ZIP)

Spouse sign here

Spouse _____ Date Signed _____ / _____ / _____

If any child is 18 years of age or older, and you are requesting dependent child coverage, they must also sign and date this section.

Print Name (Dependent) _____ Date of Birth _____ / _____ / _____

Dependent Address (Street/P.O. Box, City, State, ZIP)

Dependent sign here

Dependent _____ Date Signed _____ / _____ / _____

Print Name (Dependent) _____ Date of Birth _____ / _____ / _____

Dependent Address (Street/P.O. Box, City, State, ZIP)

Dependent sign here

Dependent _____ Date Signed _____ / _____ / _____