Regence
Life and Health Insurance Company

100 SW Market St.
P. O. Box 1271 E3-A
Portland, OR 97207-1271

# EVIDENCE OF INSURABILITY

| EVIDENCE REQUIRED BECAUSE: ☐ Over Guaranteed Issue Amount ☐ Late Enrollment | THIS APPLICATION IS FOR: ☐ Preliminary Review for Proposed New Group ☐ New Group ☐ Addition to Existing Group ☐ Change of Benefits. | GROUP NO. |
|---|---|---|
| APPLICATION IS MADE FOR: (If spouse is also applying for coverage, spouse must complete a **separate** form.) ☐ Life Amt. $____ ☐ STD Amt. $____ ☐ Dep. Amt. $____ ☐ LTD Amt. $____ | | EMPLOYEE SSN |
| NAME OF APPLICANT | ADDRESS (Street - City - State - Zip Code) | PHONE NUMBER ( ) |

| PLACE OF BIRTH | RELATIONSHIP TO EMPLOYEE | SEX M F | HEIGHT | WEIGHT | Have you gained or lost more than 20 lbs. in the last year? Give details below. ☐ YES ☐ NO |
|---|---|---|---|---|---|

| APPLICANT'S SSN (If not employee) | DATE OF BIRTH | NAME OF EMPLOYER PROVIDING INSURANCE | HIRE DATE | SALARY |
|---|---|---|---|---|

| FULL NAME & ADDRESS OF YOUR REGULAR PHYSICIAN | DATE LAST CONSULTED – give details below |
|---|---|

**Give details for any "YES" answers below.**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 1. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury? |
| ☐ | ☐ | 2. Are you now under regular medical observation or taking medical treatment or any kind of medication? |
| ☐ | ☐ | 3. Within the last five years, have you consulted a physician for any disease, injury or mental or emotional condition? Have you had or been advised to have any surgical operation or diagnostic test? |
| ☐ | ☐ | 4. Are you pregnant? **If "YES," give expected delivery date and describe any complications.** |
| ☐ | ☐ | 5. Do you use tobacco products? If "NO," have you ever used tobacco products? ☐ Yes ☐ No Date Stopped ____ |
| ☐ | ☐ | 6. Within the last ten years, have you been treated for or diagnosed as having any immune deficiency? |
| ☐ | ☐ | 7. Within the last ten years, have you been treated for or diagnosed as having or advised to take a diagnostic test for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)? |

8. Within the last ten years, have you been diagnosed or treated for any of the following:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Nervous Disorder or Epilepsy | ☐ | ☐ | Asthma or Lung Disorder |
| ☐ | ☐ | Arthritis or Related Joint Disease | ☐ | ☐ | Back Disorder |
| ☐ | ☐ | Paralysis or Stroke | ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Cancer or Tumors | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Diabetes or Albumin or Sugar in the Urine | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Disorder of the Stomach or Intestines or Liver | ☐ | ☐ | Heart Disease or Defects |

| CONDITION | DATE | REMAINING EFFECTS | PHYSICIAN'S FULL NAME & ADDRESS |
|---|---|---|---|
| | | | |

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my knowledge and belief, to be true and complete. I understand that: (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) I must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work.

**Authorization to Release Information:** I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB or other organization, institution or person that has any records or knowledge of me or my health to give the Regence Life and Health Insurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases). This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Notice of Information Practices.

**Insurance Fraud Warning:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, Regence Life and Health Insurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

**Signature of Applicant**

► ______________________________ **Date** ____________________

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# INFORMATION PRACTICES NOTICE

(Retain with your insurance records)

Thank you for enrolling for Group Insurance with Regence Life and Health Insurance Company. As a 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. Regence Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Regence Life and Health Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.