Anthem Blue Cross

Evidence of Insurability

FOR COMPANY USE ONLY
APPROVED: _____
DATE: _____

Group No.: _____

Evidence required because of:
- ☐ Over Guaranteed Issue Amount
- ☐ Late Enrollment

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

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?	☐ YES – IF SO ☐ NO	☐ GAINED ☐ LOST _____ POUNDS	GIVE DETAILS BELOW.
FULL NAME OF YOUR REGULAR PHYSICIAN					
FULL STREET ADDRESS OF YOUR REGULAR PHYSICIAN	STREET		CITY	STATE	ZIP CODE
DATE AND REASON LAST CONSULTED					

1. If employed, are you actively at work at least 20 hours a week? ..... ☐ YES ☐ NO
2. 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
3. Are you now under regular medical observation or taking medical treatment? If "YES", give details below. ..... ☐ YES ☐ NO
4. 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
5. 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
6. 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	☐	☐	Diabetes or Albumin or Sugar in the Urine	☐	☐	Lung Disorder	☐	☐
Rheumatic Fever	☐	☐	Disorder of the Stomach or Intestines or Liver	☐	☐	Kidney Disorder	☐	☐
Heart Murmur	☐	☐	Nervous Disorder or Epilepsy	☐	☐	Back Disorder	☐	☐
Heart Disease	☐	☐	Paralysis or Stroke	☐	☐			
Sexually Transmitted Disease	☐	☐	Cancer or Tumors	☐	☐			

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

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 aply 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.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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.