EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service, call 1-800-732-1603.
The applicant must sign and date this form. This form cannot be considered unless received within 30 days of the date it is dated.

Important: *Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink).*

EMPLOYER School District of Indian River County

Please check the coverage that applies.

- ❑ **Long-Term Disability POLICY** VDT 962613
- ❑ **Short-Term Disability POLICY** VDT 962612

MANDATORY DATA NEEDED: In order to process this application, this information must be completed and returned to Cigna P.O. Box 20310 Lehigh Valley, PA 18003-9924 Fax: 1-800-440-0856

CLASS _____ **LOCATION/PAYCODE #** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____
OCCUPATION _____ **VERIFIED BY** _____ **DATE** _____

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **ONGOING ENROLLMENT EVENT** ❑ **Llate entrant**

	VOLUNTARY EMPLOYEE
LONG-TERM DISABILITY AMOUNT TO BE UNDERWRITTEN	**$**
SHORT-TERM DISABILITY AMOUNT TO BE UNDERWRITTEN	**$**

EMPLOYEE SECTION

☐Mr. ☐Mrs. ☐Ms. (Check one)

Employee Name _____ **Social Security #** _____ **Birthdate** _____
Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

ACCEPTANCE/DECLINATION

In order to confirm your election, you must provide a signature for coverage(s) provided by Life Insurance Company of North America.
Signature _____ Date _____

IMPORTANT

Please complete each section that follows. Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you (i.e., the Employee) are applying for Disability Insurance more than 31 days of becoming eligible due to a life status change or during an ongoing enrollment event.

Height and Weight Information

Employee	Height	ft	in	Weight	lbs

Please indicate your answers for each question by checking the Yes or No box for the question.

	Employee **Yes**	**No**

Continue to next page in order to complete the form.

Name _____ **Social Security #** _____

Please indicate your answers for each question by checking the Yes or No box for the question.

	Employee Yes	No
1. Within the last 5 years has the proposed insured been: • diagnosed with any of the conditions shown in items A through I below, • told by a medical professional he/she has or may have any of the conditions shown in items A through I below, • or been treated by a medical professional for any of the conditions shown in items A through I below?		
A. A heart attack or stroke?	❑	❑
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	❑	❑
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	❑	❑
D. HIV infection or AIDS?	❑	❑
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	❑	❑
F. Alcohol or drug abuse or dependency?	❑	❑
G. Anxiety disorder, Bipolar Disorder or Depression?	❑	❑
H. Chronic Fatigue, Fibromyalgia or Multiple Sclerosis?	❑	❑
I. Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?	❑	❑
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	❑	❑
3. Has the proposed insured been diagnosed as pregnant within the past 10 months, or been treated for pregnancy?	❑	❑

Caution: 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.

♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to take medical tests and report the results to the Insurance Company.
(3) I must report any change in my health that happens before the insurance is effective.
(4) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Representations. Statements in the application are representations and not warranties.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Name _____ **Social Security #** _____

Short Term Disability Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Long Term Disability Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Sign Here _____ _____

Employee's Signature *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Licensed Resident Agent: Stephen C. Zilberfarb License #E108462

Return to your employer to have them complete the Employer section.
Be sure to make a copy for your own records.