



**LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
EVIDENCE OF INSURABILITY FORM
For Life Insurance**

Please fill out this application completely. It will be returned to you if any information is missing.

| 1. EMPLOYER SECTION | | | |
|----------------------------------|----------------|--------------|------------------|
| Company Name | | Group ID# | Location |
| Company Address | | City | State |
| | | | Zip Code |
| Current plan non-medical maximum | _____ Employee | _____ Spouse | _____ Child(ren) |
| Current plan overall maximum | _____ Employee | _____ Spouse | _____ Child(ren) |

| 2. EMPLOYEE SECTION | |
|--|---|
| <p>A.) Application type: (Please check all that apply.)</p> <p><input type="checkbox"/> First time coverage elected</p> <p><input type="checkbox"/> Increasing coverage amount</p> <p><input type="checkbox"/> Annual enrollment election</p> <p><input type="checkbox"/> Increasing above non-medical maximum</p> <p><input type="checkbox"/> Family Status Change:</p> <p><input type="checkbox"/> Effective date of change: _____</p> <p>Indicate Type of Family Status Change:</p> <p><input type="radio"/> Employee marriage/divorce</p> <p><input type="radio"/> Death of Spouse/Child</p> <p><input type="radio"/> Unpaid leave by Employee or Spouse</p> <p><input type="radio"/> Spouse employment status change</p> <p><input type="radio"/> Employee employment status change</p> <p><input type="radio"/> Birth/Adoption of child to Employee</p> | <p>B.) Coverage(s) Elected: Please see your Benefits Administrator with any questions. If amounts of coverage are not completed, the form will be returned to you.</p> <p><input type="checkbox"/> Employee:</p> <p>Current coverage amount \$ _____ or _____ x salary</p> <p>Additional coverage applying for \$ _____ or _____ x salary</p> <p><input type="checkbox"/> Spouse:</p> <p>Current coverage amount \$ _____</p> <p>Additional coverage applying for \$ _____</p> <p><input type="checkbox"/> Child(ren):</p> <p>Current coverage amount \$ _____</p> <p>Additional coverage applying for \$ _____</p> |

| 3. Employee Information (First Name, Last Name) (PLEASE PRINT) | | | | | | |
|--|---------------|------------|---------------------|--------|-------------------------|----------|
| Employee Name | | | Social Security No. | | Date of Hire (mm/dd/yy) | |
| | | | | | | |
| Home Mailing Address | | | City | | State | Zip Code |
| Home Phone () | Annual Salary | Occupation | Date of Birth | Height | Weight (lbs.) | M/F |

| 4. DEPENDENT SECTION Please fill out this section completely as missing information will cause a delay in processing. | | | | | | |
|---|---------------------|--------------|---------------|--------|--------|--------------|
| Dependent Information (Only needed if applying for Dependent Life coverage) (Spouse and/or Children) PLEASE PRINT | | | | | | PLEASE PRINT |
| Dependent Name | Social Security No. | Relationship | Date of Birth | Height | Weight | M/F |
| | | | | | | |
| | | | | | | |

This section requires complete answers for all applicants (dependent information only necessary if applying for Dependent Life coverage)

| | |
|---|--|
| 5. 1. Have any of the applicants had any application for life or health insurance declined, postponed or not approved as applied for? | <input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.) |
| 2. Have any of the applicants ever been disabled? | <input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.) |
| 3. Within the last 3 years, have any of the applicants consulted or been attended or examined by any doctor or other practitioner or been a patient in any hospital, clinic or similar institution? | <input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.) |
| 4. Are any of the applicants currently taking medications, prescribed or otherwise? | <input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.) |
| 5. Are any of the applicants currently pregnant? | <input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.) |
| 6. Have any of the applicants used tobacco in any form in the last 12 months? | <input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.) |

Name and address of physicians consulted _____

IMPORTANT: You must answer YES or NO to each of the following questions. Do not leave boxes blank as failure to complete all boxes with either YES or NO response will cause application to be returned.

Are any of the applicants now under treatment for, or have had or been told they had, any of the following diseases or symptoms: **(If YES, provide the name to whom it applies, with full details and dates.)**

| | | |
|---|-----------------------------|------------------------------|
| 1. BACK OR SPINAL DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 2. INTESTINAL DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 3. RESPIRATORY DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 4. HIGH OR LOW BLOOD PRESSURE | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 5. CANCER OR TUMORS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 6. ULCERS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 7. DIABETES | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 8. ALCOHOLISM | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 9. HEART DISEASE OR DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 10. THYROID DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 11. SUBSTANCE/DRUG ABUSE | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 12. STROKE OR CIRCULATORY DISEASE | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 13. GENITO-URINARY DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 14. KIDNEY OR LIVER DISORDERS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 15. MENTAL/NERVOUS/EMOTIONAL PERSONALITY DISORDER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 16. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 17. AIDS RELATED COMPLEX (ARC) | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| 18. EPILEPSY OR PARALYSIS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |

I declare that I have completed this application form and that all answers and statements are true and complete to the best of my knowledge and belief. I agree that the Insurer may rely on them in acting on this application. I understand that no insurance may become effective unless approved by the Plan Administrator and if insurance for me and my dependents (if any) is approved, it will be subject to all the terms of the policies.

6.

Employee Signature

Date

Spouse Signature

Date

RETURN THIS FORM TO:

Liberty Life Assurance Company of Boston
Attn: Group Underwriting Department
P.O. Box 1525
Dover, NH 03821-1525