

EVIDENCE OF INSURABILITY FORM

FOR OPTIONAL LONG-TERM DISABILITY INSURANCE

CIGNA Life Insurance Company of New York
New York, NY

- This form cannot be considered unless received within 30 days of completion.
- All questions must be answered completely by the applicant and the form must be dated and signed.
- Insurance for an applicant will not be effective unless and until the Insurance Company has accepted this evidence as satisfactory.
- The information on this form will be considered current for no longer than 90 days.
- Please print (preferably in black ink).

POLICY NO. _____ CLASS _____

EMPLOYER _____ WORKSITE _____ BILLING LOCATION _____

EMPLOYEE Mr. Mrs. Ms. Name _____ Social Security # _____ Birthdate _____
First Last

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Sex: M F Height: ____ft ____in Weight: ____lbs

Date of Hire _____ Base Annual Salary _____ Occupation _____ Email Address _____

Primary Physician Name _____ Address _____ Phone _____

COMPLETE QUESTIONS A-K BELOW

During the last five years, has the proposed insured been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in questions below?

Employee

Yes No

A. Cysts, moles, warts, polyps, cancer or tumor?	
B. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?	
C. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?	
D. Any alcohol and/or drug addiction and/or substance abuse; mental, emotional or any other nervous disorders?	
E. Is there a current use of prescribed medications by the proposed insured?	
F. Ever been diagnosed with or been treated for AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	
G. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through F?	
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease/disorder of the nervous system?	
I. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	
J. Any surgical operation performed or been advised to have any performed?	
K. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions A through J?	

Use the space below to provide details for "Yes" answers given above and/or medical impairments listed in questions A-K. Complete and attach a separate sheet of paper if additional space is required. Please sign and date the attachment.

Condition	Date Occurred	Duration/Treatment Received	Current Status

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Name _____ Social Security # _____

◆◆ AGREEMENTS AND AUTHORIZATIONS ◆◆

To the best of my knowledge and belief, all written, telephonic and electronic information I provided is true and complete. I also understand that the insurance I have selected for myself will begin on the effective date, provided I am actively at work on that date. If I am not, the effective date of my personal coverage, will be delayed until I am actively at work. I understand that insurance subject to medical questions requires insurance company approval, and additional medical information, including blood work, may be required to approve such insurance. I understand that I am responsible to report to the insurance company any change in my health prior to my coverage effective date, and that no coverage will be effective unless I meet the insurance company's underwriting requirements on the effective date.

Caution: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of me or my health to give any such information to CIGNA Life Insurance Company of New York and its authorized representatives and reinsurers, for use in the processing and evaluation of my application and eligibility for life or disability insurance coverage. This authorization extends to and includes information or records pertaining to psychiatric, drug or alcohol use history.

This authorization shall be valid for a period of 30 months from the date signed, and a photographic copy shall be as valid as the original. I understand that my authorized representative or I have the right to receive a copy of the authorization upon request. I understand that this authorization may be revoked provided such revocation is in writing. However, such revocation will not affect any action taken in reliance on the authorization. I further understand that this authorization is being given as a condition of obtaining insurance, and that any revocation does not affect the insurer's right to use this authorization in connection with the contest of a claim or of the policy in accordance with applicable law.

Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the Health Insurance Portability and Accountability Act. (The insurance companies are subject to the Gramm-Leach-Bliley Act and state privacy laws and do not disclose any protected information except as permitted by those laws.)

Pre-Existing Condition Limitation (applies to disability insurance only): I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the 12 months just prior to the coverage effective date) unless the disability begins more than 3 months after the effective date of coverage. Full details will be in your certificate of insurance.

Sign Here



Employee's Signature

____/____/_____
Date

TY-006978 (NY)

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 insurers' privacy practices is available upon request.