Evidence of Insurability Statement
Life Coverage
Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor/ Employer

Please Print

Complete Section A **in its entirety**. ***Be sure that*:**

- All items are completed.
- The Control Number, Suffix and Account numbers are provided (A1).
- The employee's **Social Security Number** is provided (A2).
- Both the employee's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), employee's date of hire (A6) and employee's home and work telephone numbers (A7) are provided.
- You check the appropriate box(es) for individual(s) requesting coverage. Provide the current amount of coverage, requested additional amount of coverage and resulting total amount of coverage for each individual for whom coverage is being requested (A8).
- The reason for requested coverage and Employee's Annual Earnings are provided (A9).
- Section A is signed by your Authorized Representative (A10).

Give the form to your employee for his/her confidential submission to Aetna.

Aetna will advise you of its coverage decision. Employee will be notified directly if coverage is denied.

Employee

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. ***Be sure that*:**

- All items are completed.
- Only the names of individuals requesting coverage at this time are listed (B1).
  - Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- Complete dates and details are given for all conditions checked in B3g (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the **original** to:

Aetna Life Insurance Company
Medical Underwriting Department
151 Farmington Avenue
Hartford, CT 06156-2975

1-800-660-9913

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Medical Underwriting Department
151 Farmington Avenue
Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to 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.

Attention Kentucky, Ohio and Pennsylvania Residents: 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 subjects such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Evidence of Insurability Statement
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Aetna Life Insurance Company
Medical Underwriting Department
151 Farmington Avenue
Hartford, CT 06156-2975

A. Plan Sponsor/Employer: Complete this Section - Please print.

1. Control Number	Suffix	Account	2. Employee Social Security Number
			– –

3. Plan Sponsor/Employer Name & Address	4. Employee Name & Address
ATTN:	Attn:
Name	Name
Street	Street
City State ZIP Code	City State ZIP Code

5. Plan Sponsor - Authorized Rep. Telephone Number	6. Employee Date of Hire (MM-DD-YY)	7. Employee Telephone Numbers
( ) -		Work ( ) - Home ( ) -

8. **Life Coverage Applied for:** ☐ Employee ☐ Spouse ☐ Dependent

	Employee Basic Life (Employer Paid)	**Employee Supplemental, Optional or Voluntary Life** (Employee Paid)	**Spouse Life**	**Dependents Life**
a. **Current** Amount of Life Insurance Coverage?	$	$	$	$
b. **Additional** Amount of Life Insurance Coverage requested?	$	$	$	$
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$	$	$	$

9. Reason for Requested Coverage (indicate all that apply).

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Increments ☐ Life Event/Status Change
☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Limit ☐ Other (Please explain) _____

Employee's Annual Earnings: $ _____

10. I certify the above information is correct.

Plan Sponsor/Employer - Authorized Representative Signature | Plan Sponsor/Employer - Authorized Representative Name (Please print) | Date Signed

B. Employee: Complete this Section - Please print. *All questions must be answered. Incomplete forms cannot be processed.*

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate *(MM/DD/YYYY)*	Sex	Height (ft., in.)	Weight (lbs.)
Employee:	Self				
Spouse:					
Dependent(s):					

2. Complete these questions if dependent children are listed above. ***Use Number 4 if additional space is needed.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household? If no, please explain:
b.	☐	☐	Do all dependent children depend solely on you for support? If no, please explain:
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school? If no, please explain:

3. Statement of Health for Individual(s) Listed Above. ***Use Number 4 if additional space is needed.***

	Yes	No	
a.	☐	☐	Is any individual pregnant: If yes, Who: _____ Due Date: _____ Any complications or problems:
b.	☐	☐	Has any individual used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)? If yes, who:
c.	☐	☐	Are any inpatient or outpatient medical, surgical or diagnostic procedures recommended or contemplated? If yes, When:
			Individual: _____ Name of procedure: _____ Reason for procedure:

B. Employee: Complete this Section (Continued) - Please print.

3. Statement of Health - Continued. *Use Number 4 if additional space is needed.*

	Yes	No	
d.	☐	☐	In the past 5 years has any individual been confined to a hospital, clinic, sanatorium, rehabilitation or other treatment facility? If yes, Who: _____ Why: _____ When: _____
e.	☐	☐	In the past 5 years has any individual been examined by, consulted with, or received medical treatment from any physician or practitioner for any condition other than minor illnesses (cold, flu, etc.)? If yes, Who: _____ Why: _____ When: _____
f.	☐	☐	Is any individual(s) currently taking medication(s)? If yes, complete the following information:

Name of Individual	Medication	Dosage/Frequency	Diagnosis

g. Within the past 10 years have you (or your spouse or dependent) had any disease, symptoms, impairment of or treatment (other than minor illnesses) for any of the following?

If yes, check the appropriate box(es) and describe in *Number 4*.

☐ AIDS/HIV related disorder*	☐ Cancer	☐ Kidney/Bladder	☐ Reproductive System
☐ Arthritis	☐ Carpal Tunnel Syndrome	☐ Liver/Spleen/Pancreas	☐ Skin Disorder
☐ Asthma/Emphysema/COPD	☐ Chest Pain	☐ Lungs/Breathing	☐ Stomach/Esophagus/Digestion
☐ Back/Spine/Neck	☐ Diabetes	☐ Lupus	☐ Stroke
☐ Blood/Blood Clot	☐ Ears/Eyes	☐ Mental/Emotional Condition	☐ Substance Abuse (Alcohol/Drug)
☐ Blood Pressure/Hypertension	☐ Epilepsy/Seizure	☐ Multiple Sclerosis	☐ Throat/Swallowing (GERD)
☐ Blood Vessels/Circulation	☐ Heart	☐ Muscular Condition	☐ Thyroid/Pituitary/Adrenal
☐ Bones/Joints	☐ Immune System Disorder	☐ Nervous System	☐ Tumor/Growth
☐ Brain	☐ Intestine	☐ Paralysis/Paresis	☐ Ulcer

☐ Other _____

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

4. In the space below, describe all conditions checked in question 3g above and provide additional information for questions 2a-c and 3a-f, if needed.

Ques. No.	Name of Individual	Diagnosis	Date of Onset	Details/ Symptoms	Treatment(s) Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed (Minnesota residents twelve [12] months)**. I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (*Required if spouse coverage is requested.*)	Date