Proof of Good Health Statement (Evidence of Insurability) Life and Disability Coverage

Aetna Life Insurance Company

Read this instruction page carefully.

We may contact you directly to request more information after we get back this completed statement.

Instructions

Plan sponsor (Employer)

Please print

Complete every item in Section A. ***Be sure that you*:**

- **Fill in the control number, suffix and account numbers (A1)**
- Provide the employee/member's **Social Security number** (A2)
- Show both the employee/member's and your name and address in the spaces provided (A3 and A4)
- Provide the telephone number of your authorized representative (A5), employee/member's date of hire (A7) and employee/member's home and work telephone numbers (A8)
- Give us your employee/member's and your email addresses (A6 and A10)
- Complete the employee/member's annual earnings (A9)
- **Check the appropriate box(es) for individual(s) requesting life coverage**
- **Provide the current (existing and guarantee issue) amount of coverage, the requested additional (new) amount of coverage that needs a Proof of Good Health Statement (Evidence of Insurability), and the resulting total amount of coverage. We need these items for each individual requesting coverage (A11)**
- Check the reason for requesting life coverage (A11)
- **Check the appropriate disability box(es) and provide current and requested amounts or percentage of coverage (A11)**
- **Review Section A. Make sure it's signed by your Authorized Representative (A12)**

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

Aetna will advise you of its coverage decision. We'll inform the employee/member directly if we deny coverage.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the 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 send you more follow-up questions.

Complete every item in Section B. ***Be sure that you*:**

- List only the names of individuals requesting coverage at this time (B1)
- **Provide the height and weight. If you don't, we can't process the form and will return it for you to complete (B1)**
- Give the dates and details for all conditions checked in B2g (B3)
- **Inform us of any changes in your health or changes to any information provided after you complete and sign this form and before the coverage becomes effective. Please don't complete a new form but submit a letter that includes the member ID associated with this form, applicant name(s) and health changes to the mailing address or fax number below**
- Sign the form. Get your spouse's signature if you're requesting their coverage
- **Read the Certification, Acknowledgment and Authorization before you sign the form (bottom of Section B)**

Submission and Approval

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

Aetna Life Insurance Company
Medical Underwriting Department
PO Box 83641
Lincoln, NE 68501-3641

OR

Fax to (Applications within the US): **1-800-792-9710**
Fax to (International Applications Only): **1-402-474-8426**

If you have any questions, call us at: **1-800-660-9913**

If we can't make a final underwriting decision within six months, we reserve the right to request a new Proof of Good Health Statement (Evidence of Insurability).

Once you submit the Proof of Good Health Statement (Evidence of Insurability) as required, your requested coverage will only go into effect after it's approved by Aetna.

Please note: If you don't complete and sign this form, it will delay processing.

EOI PH Sign Req'd

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Proof of Good Health Statement (Evidence of Insurability). 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, PO Box 83641, Lincoln, NE 68501-3641

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 Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island 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 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 Residents**: 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. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a 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**. **Attention Louisiana 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 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 Maryland Residents**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri 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 include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **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, the following statement applies only to your AD&D and Disability coverage**: 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. **Attention North Carolina Residents**: 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 may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents**: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention 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 Puerto Rico Residents**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents**: 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 may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents**: 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 act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington 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 include imprisonment, fines, and denial of insurance benefits.

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Medical Underwriting Department
PO Box 83641
Lincoln, NE 68501-3641
Customer Service: 1-800-660-9913

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

1. Control Number	Suffix	Account	2. Employee/Member Social Security Number

3. Plan Sponsor Name & Mailing Address

ATTN:

Name

Street

City State ZIP Code

4. Employee/Member Name & Mailing Address

Street

City State ZIP Code

5. Plan Sponsor - Authorized Representative Telephone Number ( )

6. Plan Sponsor Email Address

7a. Employee/Member Date of Hire (MM/DD/YYYY)

7b. Employee/Member Rehire Date (MM/DD/YYYY)

8. Employee/Member Telephone Numbers (Including Area Code)

a. Work ( )

b. Home ( )

c. May we leave a message? ☐ Yes ☐ No

9. Employee/Member's Annual Earnings
$

10. Employee/Member Work Email Address

11. Coverage(s) Applied for:

☐ Life* ☐ Employee/Member Basic Life ☐ Employee/Member Supplemental, Optional or Voluntary Life ☐ Spouse

	Employee/Member Basic Life	Employee/Member Supplemental, Optional or Voluntary Life	Spouse Life
a. **Current (Existing including Guarantee Issue)** Amount of Life Insurance Coverage?	$	$	$
b. **Additional (New)** Amount of Life Insurance Coverage Requesting?	$	$	$
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$	$	$

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

☐ Annual Enrollment ☐ Late Applicant ☐ Life Event/Status Change, Reason: Date:

☐ New Hire, Date: ☐ Other (Please explain)

Disability Coverages (Employee/Member Only):

☐ **Short Term Disability**: Current Amount $ or % Requesting Amount $ or %

☐ **Long Term Disability**: Current Amount $ or % Requesting Amount $ or %

12. Plan Sponsor: I certify the above information is correct.

Plan Sponsor - Authorized Representative Signature | Plan Sponsor - Authorized Representative Name (Please print) | Date Signed (MM/DD/YYYY)

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

1. Names of Individual(s) Requesting Coverage ***(Please do not include names of individuals not requesting coverage)***

Name	Relationship	Birthdate *(MM/DD/YYYY)*	Birthplace (City/State)	Gender	Height (ft., in.)	Weight (lbs.)
Employee:	**Self**					
Spouse:						

2. Statement of Health for individual(s) listed above requesting coverage. Please answer the following questions to the best of your knowledge and belief. If any of the following questions are checked "Yes", you must provide details in Number 3 below.

a. ☐ ☐ Is any individual pregnant? If **Yes**, which individual: Date due:

☐ ☐ Any current pregnancy complications or problems anticipated? If **Yes**, explain:

b. ☐ ☐ Is any individual currently using tobacco products or quit within the last 12 months (cigarettes, e-cigarettes, cigar, pipe, chewing tobacco)? If **Yes**, which individual: Quit date: Tobacco product:

c. ☐ ☐ Are any future inpatient or outpatient medical, surgical or diagnostic procedures recommended or being considered?
If **Yes**, what is the future date: Individual:
Name of procedure: Reason for procedure:

EOI

continued

Employee/Member Social Security Number

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

	Yes	No	
d.	☐	☐	In the past **7 years**, has any individual been confined to a hospital, clinic, rehabilitation or other treatment facility? If **Yes**, which individual: _____ When: _____ Why: _____ Recovery date or ongoing: _____
e.	☐	☐	In the past **7 years**, has any individual been examined, monitored, received any medical treatment, surgery or diagnostic procedure from any doctor, practitioner or counselor for any condition? If **Yes**, which individual: _____ When: _____ Why: _____ Recovery date or ongoing: _____
f.	☐	☐	Is any individual(s) **currently** taking or taken medication(s) within the last 12 months? If **Yes**, complete the following information:

Name of Individual	Medication	Dosage/Frequency	Diagnosis	Ongoing or Date Discontinued

g. Within the past **10 years**, have you or your spouse had any disease, impairment of or treatment for any of the following? **If Yes, check the appropriate box(es) and provide details in *Number 3*.**

☐ AIDS*	☐ Brain	☐ Hepatitis C	☐ Nervous System
☐ Arthritis	☐ Cancer	☐ Hypertension	☐ Paralysis/Paresis
☐ Osteoarthritis	☐ Carpal Tunnel Syndrome	☐ Immune System Disorder	☐ Peripheral Vascular Disease
☐ Psoriatic Arthritis	☐ Chest Pain	☐ Impaired Glucose Metabolism	☐ Reproductive System
☐ Rheumatoid Arthritis	☐ Chronic Fatigue/Fibromyalgia	☐ Intestine/Stomach/Ulcer	☐ Skin Disorder
☐ Other: _____	☐ Crohn's Disease/Ulcerative Colitis	☐ Kidney/Bladder	☐ Sleep Apnea/OSA
☐ Asthma	☐ Degenerative Disc Disease/Herniated Disc	☐ Liver/Spleen/Pancreas	☐ Stroke/TIA/CVA
☐ Emphysema/COPD	☐ Diabetes	☐ Lungs/Breathing	☐ Substance Abuse (Alcohol/Drug)
☐ Back/Spine/Neck	☐ Ears/Eyes	☐ Lupus Type: _____	☐ Throat/Tonsils/Swallowing
☐ Blood Disorder/Bleeding/Blood Clot	☐ Epilepsy/Seizure	☐ Mental/Emotional Condition	☐ Thyroid/Pituitary/Adrenal
☐ Blood Vessels/Circulation	☐ Esophagus/Digestion/GERD	☐ Multiple Sclerosis	☐ Tumor/Growth
☐ Bones/Joints	☐ Heart	☐ Muscular Condition	☐ 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.

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

Ques. No.	Name of Individual	Diagnosis	Date of Onset	Details/ Symptoms	Treatments Received	Full Recovery Date or is condition ongoing

☐ *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 Plan Sponsor'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, employers and the Medical Information Bureau: 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/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/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 twelve (12) months from the date signed. **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/Member'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