EVIDENCE OF INSURABILITY FORM

a CIGNA Company (herein called the Insurance Company)
For info and customer service call 1-800-345-9458
- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Return completed form to in the envelope provided to
CIGNA Group Insurance
P.O. Box 203101
Lehigh Valley, PA 18003-9924
Fax: 800.440.0856

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

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information.

EMPLOYER Shallowater ISD **Policy** TBD

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

REASON FOR REQUEST: ❑ NEW HIRE ❑ INITIAL ENROLLMENT EVENT ❑ ONGOING ENROLLMENT EVENT ❑ LATE ENTRANT

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

EMPLOYEE SECTION

❑ Mr. ❑ Mrs. ❑ Ms. (Check One)

Employee Name ________ Social Security # ________ Birthdate ________

Address ________ City ________ State ________ Zip ________

Work Phone ________ Home Phone ________ Employee ID # ________ Sex: ❑ M ❑ F

In order to confirm your election, please provide your signature: ________ Date ________

COMPLETE IF ELECTING SPOUSE COVERAGE

☐ I am currently married and my date of marriage is ________

Spouse Name (First) ________ (Last) ________ Social Security # ________

Birthdate ________ Sex: ❑ M ❑ F

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse info in this section if you (i.e., the Employee) or your spouse are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee		Spouse	
Height ft in	Weight lbs	Height ft in	Weight lbs

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

Within the last 5 years has the proposed insured been:
- diagnosed with any of the conditions shown below,
- told by a medical professional he/she has or may have any of the conditions shown below,
- or been treated by a medical professional for any of the conditions shown below?

	Employee Yes	Employee No	Spouse Yes	Spouse No
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?	❑	❑	❑	❑

2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction? ☐ ☐ | ☐ ☐

Caution: *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.*

Fold and staple to conceal health questions. Return application to your employer. Be sure to make a copy for your own records.

TL-009320 (TX)
4/2012

Name ______________________________ **Social Security #**______________________

♦ ♦ ♦ 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. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. 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 provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) 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.

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.)

Sign Here

______________________	____________	______________________	____________
Employee's Signature	*Month/Day/Year*	*Spouse's Signature (If applying for insurance for your spouse)*	*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.

Return to your employer. Be sure to make a copy for your own records.