

# LIFE INSURANCE - EVIDENCE OF INSURABILITY FORM



Life Insurance Company of North America (LINA)  
(herein called the Insurance Company) For info and  
customer service call

PO Box 20310  
Lehigh Valley, PA 18003

- The applicant must sign and date this form.
  - This form cannot be considered unless received within 30 days of the date it is dated.
- Important: Please enter all dates in mm/dd/yyyy format.

**Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.**

Employer: \_\_\_\_\_ Policy: \_\_\_\_\_  
Class: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Annual Salary: \_\_\_\_\_ Verified By: \_\_\_\_\_  
Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) \_\_\_\_\_

VOLUNTARY COVERAGE	EMPLOYEE AMOUNT
1. Enter Requested Coverage Amount (Total)	
2. Enter Current Coverage including guarantee issue (enter zero if no current coverage)	
3. Subtract Line #2 from Line # 1, this is the amount subject to Underwriting	

## EMPLOYEE SECTION

Employee Name (first, middle, last) \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ ID # \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender: ☐ M ☐ F

## IMPORTANT

Please complete each section that follows.  
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee information in this section if you 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** 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.

	Employee	
	Yes	No
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the conditions:		
A. A heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>
D. HIV Infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>
F. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>

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 must report any change in my health that happens before the insurance is 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, 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.

**Caution:** Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.



Sign Here

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*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.