# EVIDENCE OF INSURABILITY

MEDICO®
LIFE AND HEALTH INSURANCE COMPANY
*P.O. Box 10386 • Des Moines, IA 50306-0386 • Toll Free 1-800-228-6080*

Evidence Required Because of:

_____ Over Guaranteed Issue Amount

_____ Late Enrollment

This applicant is:

_____ Preliminary Review for Proposed New Group

_____ New Group

_____ Addition to Existing Group

_____ Change of Benefits

STATE GROUP DIVISION

Group No.

Application is Made For:

_____ Life Amount _____

_____ AD & D Amount _____

_____ Dep. Life _____

_____ Other _____

_____ Other _____

Name of applicant _____ If Dependent, relationship to insured _____

Name of insured _____

Address _____
STREET CITY STATE ZIP CODE

Date of Birth _____ Place of Birth _____ Social Security No. ___-___-___ Sex _____

Your Occupation _____ Employer's Name _____

Address _____
CITY STATE ZIP

Height ____ ft ____ in Weight _____ Have you gained or lost more than 20 pounds in the last year? ☐ Yes - If so ☐ No ☐ Gained ☐ Lost_____pounds **Give details below.**

Full name of your regular physician _____

Full address of your regular physician _____
STREET CITY STATE ZIP CODE

When did you last consult him/her? _____ Why? _____

1. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury? **If "YES," give details below.** ☐ Yes ☐ No
2. Are you now under regular medical observation or taking medical treatment? **If "YES," give details below.** ☐ Yes ☐ No
3. Within the last five years, have you consulted a physician for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests? **If "YES," give details below.** ☐ Yes ☐ No
4. Please check either "YES" or "NO" if you ever had been told that you had any of the following. **If "YES," give details below.**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| a. High Blood Pressure | ☐ | ☐ | e. Diabetes or Albumin or Sugar in the Urine | ☐ | ☐ | i. Cancer or Tumors | ☐ | ☐ |
| b. Immune Disorder | ☐ | ☐ | f. Disorder of the Stomach or Intestines or Liver | ☐ | ☐ | j. Lung Disorder | ☐ | ☐ |
| c. Heart Murmur | ☐ | ☐ | g. Nervous Disorder or Epilepsy | ☐ | ☐ | k. Kidney Disease | ☐ | ☐ |
| d. Heart Disease | ☐ | ☐ | h. Alcohol or Drug Addiction | ☐ | ☐ | l. Paralysis or Stroke | ☐ | ☐ |

| CONDITION | DATE | REMAINING EFFECTS | PHYSICIAN'S FULL NAME & ADDRESS |
|---|---|---|---|
| | | | |

I have read the answers and statements on this application for enrollment and agree that the above answers are complete and true to the best of my knowledge and belief.

I acknowledge receipt and understanding of "Notice of Exchange of Information" explained below.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give to the Lincoln Republic Insurance Company, or its reinsurers, any such information.

A photographic copy of this authorization shall be as valid as the original.

_____
SIGNATURE OF APPLICANT DATE

LMGA-126-LH-A/1

## TEAR OFF – FOR APPLICANT'S REFERENCE

## NOTICE OF EXCHANGE OF INFORMATION

Thank you for enrolling for Group Insurance with **Medico Life and Health Insurance Company**. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. **Medico Life and Health Insurance Company** may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates as information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

**Medico Life and Health Insurance Company** may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.