

# 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.**

- a. High Blood Pressure     Yes     No
- b. Immune Disorder         Yes     No
- c. Heart Murmur             Yes     No
- d. Heart Disease             Yes     No

- e. Diabetes or Albumin or Sugar in the Urine     Yes     No
- f. Disorder of the Stomach or Intestines or Liver     Yes     No
- g. Nervous Disorder or Epilepsy                     Yes     No
- h. Alcohol or Drug Addiction                         Yes     No

- i. Cancer or Tumors         Yes     No
- j. Lung Disorder             Yes     No
- k. Kidney Disease           Yes     No
- l. Paralysis or Stroke         Yes     No

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.