



Life Evidence of Insurability
 LTD Evidence of Insurability

Late Entrant Evidence of Insurability (Employee)
 Late Entrant Evidence of Insurability (Dependent)

EVIDENCE OF INSURABILITY INFORMATION

Attach this form with your enrollment card and submit to Jefferson Pilot Financial Insurance Company. No coverage will be effective until approved in writing by the Company. Complete all blanks in ink and print clearly. Incomplete forms will cause coverage to be delayed.

Applicant Name _____ Amount of Insurance Applying for _____ Male Female Height _____ Weight _____

Group Name (Employer) _____ Group Number _____ State of Birth _____ Date of Birth _____

Employee Name (If different than Applicant) _____ Employee Social Security Number _____

Applicant Address _____ Street _____ City _____ State _____ ZIP _____

Phone Number Home _____ Work _____ Best Time and Number to Call _____

Beneficiary (For Life or AD&D Insurance) _____ Relationship _____
(Example: Mary A. Doe, not Mrs. John Doe)

STATEMENT OF HEALTH

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Within the past 7 years, have you: (a) had, (b) been told by a physician that you had or (c) received treatment for a condition listed below? If you are not sure about an answer, your physician will be able to provide you with this information. CIRCLE CONDITIONS ANSWERED YES AND EXPLAIN IN PART 6 ON REVERSE SIDE. | | | 2. Within the past 7 years, have you been diagnosed as having: | | |
| A) Heart or artery disorder, heart attack, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> | (a) any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex), or tested positive for exposure to the HIV infection?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B) High blood pressure? If YES, last 2 readings and dates: _____ | <input type="checkbox"/> | <input type="checkbox"/> | (b) Hepatitis or any sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| C) Diabetes? If YES, age of onset, and how controlled? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 3. Within the past 5 years, have you had any physical disorder not listed above?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D) Cancer, leukemia, malignant growth or any form of tumor? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you had any physical examinations in the last 5 years? (If YES, give details in Section 6 regarding reason for exam, symptoms, treatment or medication and results). | <input type="checkbox"/> | <input type="checkbox"/> |
| E) Epilepsy or any mental/nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Are you: | | |
| F) Alcoholism, drug, or substance abuse?... | <input type="checkbox"/> | <input type="checkbox"/> | A) Under observation or receiving treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | B) Taking medication? (If YES, list below) ... | <input type="checkbox"/> | <input type="checkbox"/> |

CONDITION	NAME OF MEDICATION	DOSAGE AND FREQUENCY

6. If any YES answers to questions in Items 1 through 5 on reverse side, please explain below:

Item No(s).	Name of Individual	Condition, injury, symptom of ill health or findings of examination (if surgery performed, state type)	Onset Date Mo/Year	Date Last Treated	Results/Degree of Recovery
No(s)	Complete name, address and phone number of attending physician for each Item/Condition listed above.				
No(s)	Name & address of hospital, for each Item/Condition which required hospital stay.				

I HEREBY:

- (1) request the coverage for which I am (or may become) eligible under group policies issued by Jefferson Pilot Financial Insurance Company;
 - (2) authorize any required deductions from my earnings;
 - (3) name the above beneficiary to receive any benefits payable in the event of my death;
 - (4) represent that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed.
- I understand that for continued eligibility I must remain a full-time active employee working at least 30 hours per week.

AUTHORIZATION: I authorize any medical professional, medical facility, insurer, reinsurer, consumer reporting agency or the Medical Information Bureau (MIB) having:

- (1) information about the diagnosis, treatment or prognosis of my or my minor child's physical or mental condition; or
 - (2) any other information about me or my minor children;
- to give such information to Jefferson Pilot Financial Insurance Company or any of the above (except the MIB).

I understand Jefferson Pilot Financial Insurance Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:

- (1) to reinsurance companies, the MIB or providers of a business or legal services connected with my application; and
- (2) as otherwise may be required by law or may be further authorized by me.

I have received the Notice of Information Practices. I agree that a photocopy of this Authorization shall be as valid as the original, and that it shall be valid for 2½ years from the date signed.

NOTICE: 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.

Dated at _____ (City) _____ (State) This _____ (Month) _____ (Day) _____ (Year)

Signature of Proposed Insured

Licensed Resident Agent (signature)

Licensed Resident Agent (typed, printed or stamped)

License ID#

Home Office Use	<input type="checkbox"/> Self Bill	<input type="checkbox"/> List Bill
Approved _____	Declined _____	
EFFECTIVE DATE _____		

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Persons or organizations who wish to market products or services, including our affiliates;
6. Insurance regulatory, law enforcement or other governmental authorities;
7. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
8. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

Information disclosed will vary, depending upon the recipient and the sensitivity of the data.

MEDICAL INFORMATION BUREAU

We, or our reinsurers, may make a brief report to the Medical Information Bureau, an organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another member company for insurance, or make a claim for benefits, the Bureau may supply information in its file to such a company.

Upon receipt of a request from you, the Bureau will arrange disclosure of information in your file. If you question the accuracy of the information, you may contact the Bureau and seek correction in accordance with the Fair Credit Reporting Act. The address of the Bureau's information office is P. O. Box 105, Essex Station, Boston, MA 02112; phone number -- (617) 426-3660.

We, or our reinsurers, may also release information in our 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.

PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request correction, amendment or deletion of information which you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Home Office, you may receive a telephone call from a specially trained Home Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:

Jefferson Pilot Financial Insurance Company

P. O. Box 2616

Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS