CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY
15885 W. Sprague Road
Strongsville, Ohio 44136-1772

Evidence of Insurability Form

Part 1: To be completed by the Group Administrator/Policyholder

Group/Policyholder Name			Group Number
Street Address	City	State	Zip Code

Type/Amount of Insurance Requested:

☐ Basic Life _____ ☐ Supplemental Life _____ ☐ Voluntary Life _____

☐ Short Term Disability _____ ☐ Long Term Disability _____ ☐ Other (please specify) _____

Type/Amount of Applicant's Current Coverage(s): _____

Applicant's Current Base Annual Earnings (for Salary Based Benefits): _____ **Employee's Date of Hire:** _____

Reason for Evidence of Insurability: ☐ Amount in excess of Non Medical Maximum ☐ Late Enrollment ☐ Other: _____

Authorized Representative Name	Authorized Representative Signature	Authorized Representative Title

Part 2: To be completed by Consumers Life Insurance Company

☐ Basic Life ☐ Supplemental Life ☐ Voluntary Life

☐ Short Term Disability ☐ Long Term Disability ☐ Other: _____

Non Medical Amount: _____

☐ Approved ☐ Declined ☐ Unable to Approve

☐ Amount Approved: _____ ☐ Effective Date: _____

Reviewed By: _____ Date: _____

Part 3: To be completed by the Applicant – Separate forms are required for each Applicant

Employee Name First MI Last				Insurance is for: ☐ Employee ☐ Spouse ☐ Child
Applicant Name First MI Last	☐ Male ☐ Female	☐ Smoker ☐ Non Smoker	Date of Birth	
Street Address	City	State	Zip Code	State of Birth
Business Telephone Number Home Telephone Number	E-mail Address			
Employee's Social Security Number	Applicant's Social Security Number			

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.

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Applicant Name: _____

Part 3: (continued)

Medical Information – Please check either "Yes" or "No" in answer to each question below. "You" and "Your" refers to the Proposed Insured. Provide details to all "yes" answers in Part 4. Omitted information will cause delays.

1. Height: _____ Feet _____ Inches Weight: _____ Lbs.
2. Are you now:
   a. pregnant? ☐ Yes ☐ No
   b. taking prescribed medications or on a prescribed diet? ☐ Yes ☐ No
   c. receiving or applying for any disability benefits including workers' compensation? ☐ Yes ☐ No
3. In the past 5 years, have you received medical treatment or counseling by a physician for the use of alcohol, prescribed drugs or non-prescribed drugs? ☐ Yes ☐ No
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction: _____ ☐ Yes ☐ No
5. Have you ever been diagnosed or treated by a physician or other health care provider for:
   a. Chest pain or heart trouble? ☐ Yes ☐ No
   b. High blood pressure, stroke or circulatory disorders? ☐ Yes ☐ No
   c. Cancer or tumors? ☐ Yes ☐ No
   d. Anemia, Leukemia or other blood disorder? ☐ Yes ☐ No
   e. Diabetes? ☐ Yes ☐ No If yes, Insulin treated? ☐ Yes ☐ No
   f. Asthma, Tuberculosis, Pneumonia or other lung disease? ☐ Yes ☐ No
   g. Ulcers, stomach or liver disorder? ☐ Yes ☐ No
   h. Colitis, Crohn's or any intestinal disorder? ☐ Yes ☐ No
   i. Epilepsy, paralysis or dizziness? ☐ Yes ☐ No
   j. Mental or nervous disorder? ☐ Yes ☐ No
   k. Lyme disease, Epstein-Barr or Chronic Fatigue Syndrome? ☐ Yes ☐ No
   l. Arthritis, carpal tunnel, or any muscle weakness? ☐ Yes ☐ No
   m. Kidney or urinary tract disorder? ☐ Yes ☐ No
   n. Thyroid or other gland disorder? ☐ Yes ☐ No
   o. Back, neck or spinal disorder? ☐ Yes ☐ No
6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immune Deficiency Virus (HIV) infection? ☐ Yes ☐ No

Part 4: To be completed by the Applicant
Provide details of all "YES" answers given to questions in Part 3. If additional space is required, attach a separate signed and dated sheet.

Question #	Illness/Reason for Checkup or Doctor's Treatment/Consult	Dates From To	Full name, address and telephone # of Attending Physician or Other Practitioner

This Evidence of Insurability Form is incorporated and made part of the enrollment application.

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Applicant Name: _____

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

AGREEMENTS & AUTHORIZATION: I, the undersigned applicant, have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Consumers Life Insurance Company (CLIC) shall not be liable for any claim arising prior to the date of approval of this application at CLIC's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, prescription history database supplier, pharmacy benefit manager, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to CLIC's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize CLIC to disclose the information obtained in the consideration of my application for insurance to its reinsurers any prescription history database supplier and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation must be in writing and will have no effect on any actions taken by CLIC prior to receipt of the revocation;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until CLIC approves my application, provided that I am eligible for coverage per the terms of the policy on that day;
- I have a right to access and correction with respect to all personal information collected.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from CLIC.

If my answers on this application are incorrect or untrue, or it I refuse to sign this authorization, CLIC has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

_____ _____

Signature of Applicant Date

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Disclosure

(Please detach and retain with your insurance records)

Thank you for enrolling for Group Insurance with Consumers Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Consumers Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an 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 company, the Bureau, upon request, will supply each 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. 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 MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Consumers Life Insurance Company, its reinsurers, or designated representative(s) 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.