THE LAFAYETTE LIFE INSURANCE COMPANY (Lafayette Life)
HOME OFFICE: 1905 Teal Road, P.O. Box 7007
Lafayette, Indiana 47903
Telephone (800) 952-8486 Facsimile (765) 477-3369

Evidence of Insurability Application

Employee: Please be sure that your employer has completed the shaded box below. Then, complete all sections. Complete a separate form for your spouse, children or both only if they are applying for coverage. Read and sign this form on Page 2 (reverse) before submitting. Mail completed form to Lafayette Life PO Box 7007, Lafayette IN 47905. Questions about this form? Call 1-800-952-8486. **Please print clearly in ink. If any part of this form is not completed application will be declined.**

Policyholder Use Only: Please complete the section below before providing this form to the Employee.

Policy Number:		**Location:**		**Class:**	

Approval Requested For: ☐ Insured ☐ Dependent(s)

Total Amount of Insurance Requested:

☐ Basic Life Insurance	$	☐ STD	$
☐ Supplemental Life Insurance	$	☐ LTD	$
☐ Additional Life Insurance	$	☐ Other ___________	$

Type of Application:
☐ New Hire (over Guaranteed Issue Amount) ☐ Late Applicant or previously waived
☐ Qualifying Event (marriage, birth of child etc) Please indicate date of event: ___________________________
☐ Increase coverage. Please indicate prior amount of coverage in-force:

Employee:	$	Spouse/Child:	$

Policyholder Signature:	**Date:**

Employee Name (last, middle initial, first)			
Residence Address:			Policyholder Name
City	State	Zip	Employee Phone Number
Social Security Number	Date of Hire	Occupation	Annual Salary

Person Applying for Coverage ☐ Employee ☐ Spouse ☐ Child

Name (first, middle initial, last)	☐ Male ☐ Female	Date of Birth
Social Security Number:	Height:	Weight:

Statement of Health: If you answer “yes” to any of the questions, please write in the details of your condition (including dates, treatment and duration information) in the space provided on Page 2 (reverse). Failure to do so will cause a delay in the application process.

1. In the past 5 years, have you been diagnosed or treated by a Physician for any conditions listed below?
   - ☐ Yes ☐ No a. Dizzy spells, epilepsy, nervous or neurological disorder, migraines or mental disorder?
   - ☐ Yes ☐ No b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, COPD or lung disorder?
   - ☐ Yes ☐ No c. Abnormal blood pressure, chest pains, heart murmur, heart disease or heart attack?
   - ☐ Yes ☐ No d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs?
   - ☐ Yes ☐ No e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder?
   - ☐ Yes ☐ No f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus?
   - ☐ Yes ☐ No g. Sugar in urine, diabetes, kidney or bladder disorder?
   - ☐ Yes ☐ No h. Anemia, blood vessel disease, bleeding or any other blood disorder?
   - ☐ Yes ☐ No i. Difficulty with eyes or ears?
   - ☐ Yes ☐ No j. Chronic fatigue or fibromyalgia?

2. ☐ Yes ☐ No a. Are you currently pregnant? If yes, how many months? _________

☐ Yes ☐ No b. Have you ever had a complication of pregnancy?

3. In the past 5 years, have you:
   - ☐ Yes ☐ No a. Had surgery, injuries or been treated at a hospital, clinic or other health care facility?
   - ☐ Yes ☐ No b. Been off work for more than 5 consecutive days due to illness or injury?
   - ☐ Yes ☐ No c. Lost 10 lbs. or more in a 12 month period? If yes, amount: _____ lbs.
   - ☐ Yes ☐ No d Had a driver's license restricted, suspended, revoked, or been convicted of drunk driving?

4. ☐ Yes ☐ No a. Do you engage or expect to engage in any of the following activities: scuba diving, bungee jumping, skydiving, parachuting, hang gliding, racing (automobiles or motorcycles), ballooning or mountain climbing? If yes, indicate below which activity, how often and last time participated?

5. In the past 5 years, have you:
   - ☐ Yes ☐ No a. Been refused life or health insurance, or offered it on special terms?
   - ☐ Yes ☐ No b. Been diagnosed as having, or been treated for HIV/Acquired Immune Deficiency Syndrome (AIDS)?

Statement of Health – Detail: If you answer 'yes' to any of the questions above, please provide details in the provided space below. If you need additional space, check here ☐ and attach a separate sheet.

#	**Description/History of Condition** Example: High Blood Pressure; most recent BP reading etc.	**Date** (mm/dd/yy)	**Physician Name**	**City, State**

I Hereby:

1. request the coverage for which I am (or may become) eligible under a group policy issued by Lafayette Life;
2. authorize any required deduction from my earnings;
3. 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 Actively Working at least the minimum hours as outlined in this Policy. With regards to coverage on a Dependent, a Dependent's life insurance will not become effective when:

1. the Dependent is confined at home, in a hospital, to a convalescent facility, to a health care facility, to a nursing home, or elsewhere when the insurance would otherwise become effective or;
2. the Employee is not insured under this Policy; or
3. the Dependent is unable to perform all the usual and customary duties or activities of an individual in good health and of the same age and gender, except as otherwise provided in this Policy.

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

1. information about the diagnosis, treatment or prognosis of my or my dependents physical or mental condition;
2. prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources; or
3. any other information about me or my dependents;

to give such information to Lafayette Life and its reinsurers.

I understand that Lafayette Life 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 service concerned with my application; and
2. as otherwise may be required by law or may be further authorized by me.

Date:_____________ **Signature:**____

REQUIRED FRAUD WARNINGS:

ARKANSAS, LOUISIANA OR NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company, penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DELAWARE OR IDAHO: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: Warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

INDIANA: A person who knowingly, and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

KANSAS: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MAINE OR TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who submits an application or files a claim with intent to defraud or help commits a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to civil and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud

OKLAHOMA: Warning: any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

PENNSYLVANIA: 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.

Home Office Use:

☐ **Approved** ☐ **Declined** **Reason:** ______________________________

Effective Date: ______________________ Examiners Initials: ______________________________

Notes: ____

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INSURANCE INFORMATION PRACTICES

The Lafayette Life Insurance Company
(Lafayette Life)
1905 Teal Road, P.O. Box 7007
Lafayette, Indiana 47903

TO: Our Applicants and Proposed Insureds:

Lafayette Life's policy and practice is to conduct its business so as to protect the privacy of its policyholders, eligible employees or members, agents and employees of Lafayette Life. This description of the Insurance Information Practices is being provided pursuant to the requirements of the Insurance Information and Privacy Protection Law of several states and the Fair Credit Reporting Act.

Collection of Information

In order to properly evaluate your application for insurance and administer your policy, if issued, we must collect certain necessary and helpful information. The amount and type of information collected may vary depending on the amount and type(s) of coverages requested, but in general we will be seeking information about the age, occupation, physical and mental condition, health history, environment, mode of living, general reputation, avocations, finances, and other personal characteristics of the applicant and all persons proposed for insurance. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examinations, if required, and any reports Lafayette Life may receive from doctors and hospitals who have attended you. In addition, an agent may collect information intended to aid in the analysis, updating and improvement of your insurance programs.

You are our most important source of information and your application is our primary source of data. Its accuracy is vital to our evaluation and later policy administration. We may also collect or check information by contacting medical professionals and institutions disclosed in the application which have provided care to you or members of your family proposed for insurance, employers and business associates, friends and neighbors, governmental agencies which maintain public records about you and other insurance companies with whom you have dealt. We may collect information by exchanges of correspondence, by telephone or by personal contact.

Fair Credit Reporting Act Notice

You are advised that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, credit standing, insurability, and mode of living. It is not limited to information regarding a person’s medical history or conditions. You have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation. You may request to be interviewed in connection with an investigative consumer report by checking the box on the attached authorization. On request, you are entitled to receive a copy of the investigative consumer report if no interview is conducted.

We may seek information from the Medical Information Bureau (M.I.B., Inc.). In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs services.

M.I.B. Pre-Notice

Information regarding your insurability will be treated as confidential. Lafayette Life or its reinsurers, may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The purpose of the Bureau is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by the Bureau may alert the insurer to the possible need for further investigation. The Bureau is not a repository for medical reports from hospitals and physicians, and information in the Bureau file does not reveal whether applications for insurance are accepted, rated, or declined. 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 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, Massachusetts 02112, telephone number (617) 426-3660.

Lafayette Life 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.

Usually, information will be sent to third parties only if you authorize us to do so. But in some circumstances, we will make disclosures of personal information without authorization to third parties. The following list is a description of persons or organizations to whom certain items of information might be disclosed:

Persons or organizations which perform professional, business or insurance functions for Lafayette Life such as professional consultant and examiners, group plan administrators, or insurance claim investigators.

Agents, consumer reporting agencies hired to prepare investigative consumer reports, and other insurance companies to which you have applied for insurance or benefits.

Your attending physician or treating medical professional.

Persons or organizations conducting bona fide financial audits or evaluations for us.

This list describes some disclosures which may be made; such disclosures are not always or even often made. In any event, information disclosed without your authorization will be only as much as is reasonably necessary to accomplish the intended purpose.

A description of the circumstances in which information about you might be disclosed to the types of persons and organizations referred to above will be sent to you upon request.

We will write to you if we cannot provide the insurance you have requested or if we can only provide it on a modified basis or at a premium which is more than our Standard Rate. We will tell you, in general terms, of the reasons for our decision. Upon written request, more specific reasons and information will be given to you.

Access and Correction of Personal Information

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to ask about personal information which we may have in our files and the right to seed a correction of information you think is wrong.

We have procedures by which you can obtain access to personal information collected about you appearing in our policy files, including investigative consumer reports. We also have procedures by which you may request correction, amendment or deletion of any information in our policy files which you believe to be inaccurate. A description of these procedures will also be sent to you upon request to the Company's Home Office.

Requests for Additional Information

If you have any further questions or wish to request additional information, please write to Lafayette Life, Attention: Group Communication Dept., P.O. Box 7007, Lafayette, Indiana 47903.

AUTHORIZATION TO RELEASE INFORMATION

for

The Lafayette Life Insurance Company

I (We) authorize any: (1) licensed physician, (2) health care practitioner, (3) health care professional, (4) osteopath, (5) chiropractor, (6) hospital, (7) medical or mental clinic, (8) sanatorium, (9) other health care provider or other health care facility, (10) law enforcement agency, (11) corner, (12) insurance company or affiliate or subsidiary of any insurance company, (13) third party administrator, (14) Lafayette Life, (15) consumer reporting agency, (16) employer (whether past or present), (17) insurance support organization, (18) the Veterans Administration, (19) the Veteran's Administration, and

(20) the Medical Information Bureau (M.I.B., Inc.) that has any personal information, records (of any type or nature), health history or medically related knowledge of me or my minor child(ren) proposed for insurance to release information about me and my minor child(ren) to the persons or organizations described below.

I (We) authorize any person or institution to release and give copies of all records of health history, treatment, and diagnosis, and all reports , including reports of all present or past physical, mental or medically related conditions (including conditions or information occurring or in its hands after the date and during the validity of this authorization) concerning me or my minor child(ren) to the following persons or organizations: Lafayette Life, its reinsurers, authorized representatives, insurance support organizations or investigating agents or agencies hired by Lafayette Life or employees of Lafayette Life who have been requested to secure such information.

I (We) also authorize Lafayette Life or its reinsurers or authorized claim representatives to release any information collected about me or my minor child(ren) to Medical Information Bureau (M.I.B., Inc.) and to other insurance companies with whom I (We) have policies or to whom I (We) may apply for insurance.

I (We) understand that this information is needed for, and will be used to evaluate, an application for life insurance or to evaluate a claim for insurance benefits.

I (We) authorize Lafayette Life to obtain an investigative consumer report on me and on any member of my family proposed for insurance.

A photocopy of this Authorization will be as valid as the original. This Authorization will be valid from the date signed for a period of twenty-four (24) full months or less, if required by applicable state law (e.g. MINNESOTA - Authorization limited to twenty-six (26) months).

I (We) understand that I (We) can receive a copy of this Authorization upon request and I (We) acknowledge receipt of the Description of Insurance Information Practices, which contains a reprinted copy of this Authorization, the Medical Information Bureau Pre-Notice and the Fair Credit Reporting Act Notice.

☐ I (We) elect to be interviewed if an investigative consumer report is prepared in connection with the application for insurance.

[DETACH AND KEEP FOR YOUR RECORDS]

AUTHORIZATION TO RELEASE INFORMATION

The Lafayette Life Insurance Company

I (We) authorize any: (1) licensed physician, (2) health care practitioner, (3) health care professional, (4) osteopath, (5) chiropractor, (6) hospital, (7) medical or mental clinic, (8) sanatorium, (9) other health care provider or other health care facility, (10) law enforcement agency, (11) corner, (12) insurance company or affiliate or subsidiary of any insurance company, (13) third party administrator, (14) Lafayette Life, (15) consumer reporting agency, (16) employer (whether past or present), (17) insurance support organization, (18) the Veterans Administration, (19) the Veteran's Administration, and (20) the Medical Information Bureau (M.I.B., Inc.) that has any personal information, records (of any type or nature), health history or medically related knowledge of me or my minor child(ren) proposed for insurance to release information about me and my minor child(ren) to the persons or organizations described below.

I (We) authorize any person or institution to release and give copies of all records of health history, treatment, and diagnosis, and all reports , including reports of all present or past physical, mental or medically related conditions (including conditions or information occurring or in its hands after the date and during the validity of this authorization) concerning me or my minor child(ren) to the following persons or organizations: Lafayette Life, its reinsurers, authorized representatives, insurance support organizations or investigating agents or agencies hired by Lafayette Life or employees of Lafayette Life who have been requested to secure such information.

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☐ I (We) elect to be interviewed if an investigative consumer report is prepared in connection with the application for insurance.

Date: ______________________________

____
Signature of Proposed Insured or,
Parent of Minor Proposed Insured

FULL NAMES OF CHILDREN PROPOSED
FOR INSURANCE

____
Print Name of Minor Child

____
Signature of Proposed Insured Spouse
(Not needed when spouse will not be Insured)

____
Print Name of Minor Child

____
Print Name of Minor Child

Witness: ______________________________
(Agent, if present)

[DETACH AND SEND WITH APPLICATION]

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO THE LAFAYETTE LIFE INSURANCE COMPANY

The Lafayette Life Insurance Company
1905 Teal Road, P.O. Box 7007
Lafayette, Indiana 47903

This authorization complies with the HIPAA Privacy Rule

____ ________________________
Name of Proposed Insured/Patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“My Providers”) to disclose my entire medical record and any other protected health information concerning me to The Lafayette Life Insurance Company and it’s agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Lafayette Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct any other legally permissible activities that relate to any coverage I have or have applied for with The Lafayette Life Insurance Company.

This authorization shall remain in force for [[twenty-four (24)] months] following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Lafayette Life Insurance Company at 1905 Teal Road, P.O. Box 7007, Lafayette, Indiana 47903-7007, Attention: Group Communication Dept. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Lafayette Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Lafayette Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____ ______________________
Signature of Proposed Insured/Patient or Personal Representative Date

____
Description of Personal Representative’s Authority or Relationship to Patient

One copy of this Authorization for Proposed Insured/Patient or Personal Representative
One copy of this Authorization is to be sent to the Home Office

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO THE LAFAYETTE LIFE INSURANCE COMPANY

The Lafayette Life Insurance Company
1905 Teal Road, P.O. Box 7007
Lafayette, Indiana 47903

This authorization complies with the HIPAA Privacy Rule

____ _______________________

Name of Proposed Insured/Patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Lafayette Life Insurance Company and it's agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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This protected health information is to be disclosed under this Authorization so that The Lafayette Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct any other legally permissible activities that relate to any coverage I have or have applied for with The Lafayette Life Insurance Company.

This authorization shall remain in force for [[twenty-four (24)] months] following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Lafayette Life Insurance Company at 1905 Teal Road, P.O. Box 7007, Lafayette, Indiana 47903-7007, Attention: Group Communication Dept. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Lafayette Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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____ ______________________

Signature of Proposed Insured/Patient or Personal Representative Date

____

Description of Personal Representative's Authority or Relationship to Patient

One copy of this Authorization for Proposed Insured/Patient or Personal Representative
One copy of this Authorization is to be sent to the Home Office