GROUP INSURANCE HEALTH STATEMENT
COMPANION LIFE INSURANCE COMPANY
Evidence of Insurability

Administered by:
Companion Life Insurance Company
800 Main Street, P.O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: 877-676-5789
Fax: 563-557-3351

Underwritten by:
Companion Life
P.O. Box 100102 | Columbia, S.C. 29202-3102
800-753-0404 (Phone) | 800-836-5433 (Fax)

PROPOSED INSURED (EMPLOYEE INFORMATION – to be completed by the Employee/Enrollee)
Employee's Name: _____ Employee's SSN: _____
Employee's Date of Birth: _____ Group Name: _____ Group #: _____
Employee's Address: _____ Employee's Phone: _____

You must provide the following health information to obtain the requested insurance coverage if:
(1) You are required by Companion Life Insurance Company to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) (For Life) your application for coverage is being made more than 31 days after you originally became eligible for this coverage. PLEASE ANSWER EVERY QUESTION AND COMPLETE EVERY SPACE. Complete for spouse and child(ren) (if applicable) if applying for Voluntary Life Insurance Coverage.

Name and address of the doctor or facility that has any Proposed Inured(s) medical records		
Employee's Doctor:	Spouse's Doctor:	Child's Doctor:
Address:	Address:	Address:

PROPOSED INSUREDS (EMPLOYEE INFORMATION – to be completed by the Employee/Enrollee)	
Employee: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year? ☐ Yes ☐ No If yes, amount gained or lost: _____ (Explain below)	Spouse: Height:_____ Weight:_____ Have you gained or lost more than 20 pounds in the last year? ☐ Yes ☐ No If yes, amount gained or lost: _____ (Explain below)

Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Within the past 10 years has any Proposed Insured:						
a. Had an application for life or health insurance, or for reinstatement thereof, declined or modified?	☐	☐	☐	☐	☐	☐
b. Applied for or received any disability compensation?	☐	☐	☐	☐	☐	☐
c. Flown or intended to fly as a pilot, student pilot, or crew member?	☐	☐	☐	☐	☐	☐
2. Has any Proposed Insured used tobacco products in the past 12 months?	☐	☐	☐	☐	☐	☐
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	☐	☐				
4. Within the past 10 years, has any Proposed Insured been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. Coronary artery disease, abnormal blood pressure, diabetes, or cancer?	☐	☐	☐	☐	☐	☐
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary, or nervous system?	☐	☐	☐	☐	☐	☐
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV) or any other immune deficiency disorder?	☐	☐	☐	☐	☐	☐
d. Drug or alcohol dependency or abuse?	☐	☐	☐	☐	☐	☐
e. Have you been diagnosed with, treated for (including any prescription medications), or lost time from work due to any condition relating to the following: Bone, Joint, Spine, Muscle, or Connective Tissue?	☐	☐	☐	☐	☐	☐
5. Has any Proposed Insured ever been a patient in a hospital, mental health facility, or institution in the last five years?	☐	☐	☐	☐	☐	☐
6. Has any Proposed Insured been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	☐	☐	☐	☐	☐	☐
7. During the past 5 years, has any Proposed Insured been advised by a member of the medical profession to be hospitalized or to have any medical or surgical procedures or diagnostic tests performed that have not been completed or for which results have not been received, or undergone evaluation following abnormal test results?	☐	☐	☐	☐	☐	☐
8. To the best of your knowledge and belief, is any Proposed Insured now pregnant?	☐	☐	☐	☐	☐	☐

9. Give the name and address of your personal physician and the date and reason for your last consultation.

Name: _____

Address: _____ Date: _____

Reason: _____

Enter complete details for questions 4-9 that were answered "YES" above. If more space is needed, attach an additional sheet. <u>FULL DETAILS</u> includes: nature of illness or injury, number of attacks, duration, severity, treatment, results, prognosis, and any other pertinent

Question No.	Name	Onset Date MM/DD/YYYY	Full Details	Medical Care Provider's Name/Address/Phone

I have _____ (number) children eligible as defined in the group policy and certificate.

I hereby certify that the answer to each of the above questions is complete and true to the best of my knowledge and belief, that such answers have been fully and correctly recorded, that no material information concerning any Proposed Insured's past or present health has been omitted, and that the statements in this application are representations and not warranties. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by Companion Life Insurance Company.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company and Medicare Part A and Part B carrier that has any records or knowledge of me, my spouse, and all dependent children proposed for coverage, or our health, to give Companion Life Insurance Company or their reinsurers any such information. I understand that Companion Life Insurance Company will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization Companion Life Insurance Company may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be valid as the original.

Any person who knowingly presents a false or fraudulent statement in an application for insurance may be guilty of a criminal offense and subject penalties under state law.

_____ Date _____
Signature of Proposed Insured (Employee)

_____ Date _____
Signature of Spouse (if Proposed Insured)