

EVIDENCE OF INSURABILITY



Lincoln Mutual
 Life & Casualty Insurance Company
 4510 13th Avenue South • P.O. Box 1918
 Fargo, North Dakota 58107-1918

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

Group No. _____
STATE GROUP DIVISION

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 Gained
 No 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 <input type="checkbox"/>	No <input type="checkbox"/>	e. Diabetes or Albumin or Sugar in the Urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	i. Cancer or Tumors	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Immune Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	f. Disorder of the Stomach or Intestines or Liver	Yes <input type="checkbox"/>	No <input type="checkbox"/>	j. Lung Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	g. Nervous Disorder or Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	k. Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d. Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	h. Alcohol or Drug Addiction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	l. Paralysis or Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 Mutual Life and Casualty 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 **Lincoln Mutual Life and Casualty 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. **Lincoln Mutual Life and Casualty 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.

Lincoln Mutual Life and Casualty 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.