# Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Evidence of Insurability

**Please note:** Failure to accurately and legibly complete this enrollment application may result in delayed processing

**Pre-notice**
The notification below must be given to the proposed insured before the application is completed

Cut-----------------------------------------------------------------------------------------------------------------------------
(remove for your records)

**Disclosure of personal and health information**
Blue Shield of California Life & Health Insurance Company ("Blue Shield Life") understands the importance of keeping your and your dependents' personal and health information private. Blue Shield Life protects this information in electronic, written, and oral forms when used throughout our company. Only qualified members of Blue Shield Life's staff, its third-party administrators, its reinsurers, or its legal representatives will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. You have a right of access and correction with respect to all personal information collected, including information contained in investigative consumer reports, and to receive a copy of this authorization. Your authorization will govern our request for information and any later disclosure of that information. Your authorization is valid for 30 months from the date it is signed.

Blue Shield Life will not disclose this information without your authorization except as permitted by law.

A complete explanation of Blue Shield Life's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's website. Please send written requests to Blue Shield of California Life & Health Insurance Company, 4203 Town Center Blvd., El Dorado Hills, CA 95762.

**Medical Records and Fair Credit Reporting Act pre-notice**
During the approval process, Blue Shield Life relies primarily on information provided by you. However, Blue Shield Life may supplement that information with information from other sources, such as medical practitioners or other medically related facilities that may have records or knowledge of the insured's health.

In some cases, Blue Shield Life may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You may request to be interviewed in connection with the preparation of this report. In compliance with the Fair Credit Reporting Act, (the "Act"), we are informing you that as part of our routine procedures, an investigative consumer report including information as to character, general reputation, personal characteristics, and mode of living may be made. Under the Act, 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. The investigation (which may include personal interviews) concerns residence verification, marital status, number of children, economic status, employment, occupation, general health, habits, reputation, and mode of living. If the application is for family insurance or any other type of insurance on your spouse/domestic partner or minor child, this notice is also being given to you as the representative of said spouse/domestic partner or minor child named in the application. You may also request from the consumer reporting agency a written summary of your rights under the Fair Credit Reporting Act.

**MIB, Inc. pre-notice**
Blue Shield Life, its third-party administrators, or its reinsurers may make a brief report to MIB, Inc. concerning factors that affect the insurability of any person for whom coverage is being requested. MIB, Inc. is a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB, Inc.'s website is www.mib.com.

Blue Shield Life, its third-party administrators, or its reinsurers 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 has been submitted.

**For your protection California law requires the following to appear on this form:** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## Part 1. Employer/agency to complete

**Please type or use black ball-point pen. Do not use correction fluid.** Please complete Part 1 in its entirety, including your group number, company name, and address. If you are unsure whether or not to complete this form, please consult your Schedule of Benefits.

Evidence of Insurability is required for:

1. Late enrollments –
   A late enrollment occurs when an employee has not enrolled within 31 days of date of eligibility for coverage where the employer contributes premium. IF evidence is required for a late enrollment, please check the box and complete the total amount requested column. Guarantee issue amount does not apply to late enrollment.
2. Amounts in excess of guarantee issue limit –

   The guarantee issue limit is listed on the schedule of benefits.

   If evidence is required due to amounts in excess of guarantee issue limits, please check the applicable product box and fill in the appropriate amounts of insurance and guaranteed issue in columns 1-4 of the applicable product table. The total amount requested column should be no greater than the amount(s) the employee would be entitled to if approved and actively at work.

Please have employee complete Parts 2, 3, and 4, in their entirety, sign and date. Please be sure that the employee detaches the disclosure statement.

- If you have checked **NEW GROUP**, please submit these forms along with your application or for group insurance participation agreement to your sales representative or broker
- If you have checked **ADDITION TO EXISTING GROUP**, please send to Blue Shield of California Life & Health Insurance Company, c/o HOVIN Underwriting Partners, Inc., 30 Tower Lane, Ste. 495, Avon, CT 06001 Fax: (800) 329-2742, Email: EOI@blueshieldca.com

**This enrollment form is for a(n):**

New group

Addition to existing group

**Type of application** (check one)**:**

New hire

Increase in coverage

Late enrollment

Group name and address

Completed by

Print name and title

Telephone

Group number

| Check applicable product(s) | Current amount or initial request amount | Additional requested amount | Guaranteed issue amount | Total amount requested |
|---|---|---|---|---|
| Basic & life AD&D | | | | |
| Dependent life | | | | |
| Supplemental life | | | | |
| Supplemental life-Spouse/domestic partner | | | | |
| Supplemental life-Child/ren | | | | |
| Voluntary life | | | | |
| Voluntary life-Spouse/domestic partner | | | | |
| Voluntary life-Child/ren | | | | |

## Parts 2 to 4: Employee to complete

**Please type or use black ball-point pen. Do not use correction fluid.** Complete Parts 2, 3, and 4.

**Part 2**

Fill in only the names of individuals for which Evidence of Insurability is required. For example, if you are not applying for dependent life, you do not need to list spouse/domestic partner and dependent names.

Please make sure that you always complete the date and state of birth, height, and weight for each individual.

**Parts 3 and 4**

Answer all health questions and give details in the space provided in Part 4 only for "Yes" answers. Sign and date the form (spouse's/domestic partner's signature, if applicable) and detach the pre-notice for your records.

## Part 2. Employee, spouse/domestic partner, and dependent children information *(to be completed by employee)*

| Employee last name | | | Employee first name | | Middle initial | Home phone # | Work phone # |
|---|---|---|---|---|---|---|---|
| Occupation | | | Base annual earnings | Sex<br>M F<br>Nonbinary | Social Security number | | |

| Home address | City | State | ZIP | Date of birth | Birthplace (State or country) | Height ft. in. | Weight |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Name | Sex | Date of birth | Birthplace | Height | Weight |
|---|---|---|---|---|---|
| Spouse/domestic partner name (If applying for dependent coverage) (Last, first, initial) | Sex<br>M F<br>Nonbinary | Date of birth | Birthplace (State or country) | Height ft. in. | Weight |
| Unmarried dependent children (Give first and last name(s) | Sex<br>M F<br>Nonbinary | Date of birth | Birthplace (State or country) | Height ft. in. | Weight |
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## Part 3. Employee, spouse/domestic partner, and dependent children health questionnaire *(to be completed by employee)*

Answer YES/NO to each question & provide any requested information in the space provide and/or in Part 4. If additional space is required, attach a separate signed, and dated sheet. If you are not sure about an answer, your physician will be able to provide you with this information.

1. Within the last 5 years, has a medical professional ever diagnosed or treated you or any of your dependents for any of the following: (CIRCLE CONDITIONS ANSWERED "YES" and provide additional details in Part 4.)
   - A. Disease of the heart or arteries, including but not limited to, heart attack, irregular heart murmur, coronary heart disease, heart surgery — YES NO
   - B. Disease of the liver, including but not limited to, hepatitis, cirrhosis of the liver, liver failure — YES NO
   - C. Disease of the kidneys, including but not limited to, end stage renal disease — YES NO
   - D. Disease of the lungs, including but not limited to, asthma, emphysema, tuberculosis, COPD, sleep apnea — YES NO
   - E. Disease of the stomach or intestines, including but not limited to, ulcers, colitis — YES NO
   - F. High blood pressure — YES NO
     If YES, last 2 readings and dates:
   - G. Diabetes — YES NO
     If diabetic, age of onset, how controlled?
   - H. A cancer or tumor, including but not limited to, melanoma, Hodgkin's disease, lymphoma, and leukemia — YES NO
   - I. Diagnosis of epilepsy, depression, or any mental/nervous disease — YES NO
   - J. Paralysis, stroke, TIA, convulsions, or seizure — YES NO
   - K. Alcoholism, drug, or substance abuse — YES NO
   - L. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), excluding a positive HIV test — YES NO
2. Within the last 5 years, have you or any of your dependents had any surgery — YES NO
3. Are you or any of your dependents:
   - A. Currently receiving treatment from a medical professional — YES NO
   - B. Currently taking any prescribed medication, or have you taken any prescribed medication during the past 12 months — YES NO
     If YES to either (A) or (B), provide details here (you may also provide more details in Part 4):
4. Have you or any of your dependents ever used nicotine product(s) including tobacco — YES NO
   If YES, describe type of product(s), the frequency, the number of years, and if stopped, when (provide more details in Part 4):
5. Have you or any of your dependents ever been denied life or health insurance — YES NO
   If YES, give date and reason (you may provide additional details in Part 4):
6. Have you or any of your dependents been convicted of three or more moving violations within the past three years, or have you ever been convicted of driving under the influence of alcohol or drugs — YES NO
   If YES, provide details, as well as your driver's license number (you may provide additional details in Part 4):

## Part 4. Provide details of any “YES” answers given in Part 3 *(to be completed by employee)*

If additional space is required, attach a separate signed and dated sheet. Please be sure to identify which question number you are referencing and to which family member it applies, i.e., self, spouse/domestic partner/dependent child(ren)

| Question number and who it refers to | Name of condition, disease, or disorder and/or all prescription medications | Dates from – to | Attending physician’s name, address, and phone number | Any additional details |
|---|---|---|---|---|
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**AUTHORIZATION** - The following authorization section is to be signed by all employees applying for coverage with Blue Shield of California Life & Health Insurance Company (“Blue Shield Life”). **This enrollment cannot be processed without your signed authorization.**

**I* agree** I have read, or have had read to me, the completed application and pre-notice and agree that all above statements are complete, true, and correctly recorded to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I also understand that any person who makes a false statement in the application with an intent to deceive or that materially affects the acceptance of the risk or the hazard assumed by Blue Shield Life or its reinsurers, may be barred the right of recovery under this policy. Validity of the coverage will not be contested, except for nonpayment of premiums, after it has been in force for two years.

I hereby authorize Blue Shield Life or its reinsurers to make a brief report on the statements herein to the MIB, Inc. , a not-for-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. Blue Shield Life or its reinsurers 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 of benefits has been submitted. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB, Inc., or investigative reporting services that has any records or knowledge of me or my health, to give to Blue Shield Life or its reinsurers any such information, including drug or alcohol use or abuse, mental illness, AIDS, or other sexually transmitted diseases, excluding HIV.

I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report and that I am entitled to receive a copy of a conducted investigative consumer report upon request. I acknowledge that I have received the Fair Credit Reporting Notice. This authorization will be valid from the date signed for a period of 30 months. A photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy.

I understand that coverage does not become effective until this and my employer’s application have been approved by Blue Shield Life.

* **“I” includes any adult over age 18 applying for coverage.**

Signature of employee ______________________________

Dated at ______________________________ on ______________________________
City, state Month, day, year

Signature of spouse/domestic partner (if applicable) ______________________________ Dated ______________

Signature of dependent (18 years or older (if applicant) ______________________________ Dated ______________

Signature of dependent (18 years or older (if applicant) ______________________________ Dated ______________