



**LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
EVIDENCE OF INSURABILITY FORM
For Disability Insurance Coverage**

Please fill out this application completely. It will be returned to you if any information is missing.

1. EMPLOYER SECTION

Company Name		Group ID#	Location
Company Address	City	State	Zip Code

2. EMPLOYEE SECTION

A.) Coverage(s) Elected:

Short Term Disability (STD) (Employee Only)

Long Term Disability (LTD) (Employee Only)

B.) Application Type (Please check all that apply):

First time coverage elected

Increasing coverage amount
From: _____ To: _____

Annual enrollment election

Family Status Change:
Effective date of change: _____
Indicate type of Family Status Change:

Employee marriage/divorce

Death of Spouse/Child

Unpaid leave by Employee or Spouse

Spouse employment status change

Employee employment status change

Birth/Adoption of child to Employee

Please see your Benefits Administrator with any questions.

3. Employee Information (First Name, Last Name) (PLEASE PRINT)

Employee Name		Social Security No.		Date of Hire (mm/dd/yy)	
Home Mailing Address		City	State	Zip Code	
Home Phone ()	Annual Salary	Occupation	Date of Birth	Height	Weight (lbs.) M/F

This section requires complete answers for all applicants (dependent information only necessary if applying for Dependent Life coverage)

4. 1. Have any of the applicants had any application for life or health insurance declined, postponed or not approved as applied for?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
2. Have any of the applicants ever been disabled?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
3. Within the last 3 years, have any of the applicants consulted or been attended or examined by any doctor or other practitioner or been a patient in any hospital, clinic or similar institution?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
4. Are any of the applicants currently taking medications, prescribed or otherwise?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
5. Are any of the applicants currently pregnant?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
6. Have any of the applicants used tobacco in any form in the last 12 months?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)

Name and address of physicians consulted _____

PLEASE COMPLETE REVERSE SIDE ALSO

IMPORTANT: You must answer YES or NO to each of the following questions. Do not leave boxes blank as failure to complete all boxes with either YES or NO response will cause application to be returned.

Are any of the applicants now under treatment for, or have had or been told they had, any of the following diseases or symptoms: **(If YES, provide the name to whom it applies, with full details and dates.)**

1. BACK OR SPINAL DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
2. INTESTINAL DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
3. RESPIRATORY DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
4. HIGH OR LOW BLOOD PRESSURE	<input type="checkbox"/> NO	<input type="checkbox"/> YES
5. CANCER OR TUMORS	<input type="checkbox"/> NO	<input type="checkbox"/> YES
6. ULCERS	<input type="checkbox"/> NO	<input type="checkbox"/> YES
7. DIABETES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
8. ALCOHOLISM	<input type="checkbox"/> NO	<input type="checkbox"/> YES
9. HEART DISEASE OR DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
10. THYROID DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
11. SUBSTANCE/DRUG ABUSE	<input type="checkbox"/> NO	<input type="checkbox"/> YES
12. STROKE OR CIRCULATORY DISEASE	<input type="checkbox"/> NO	<input type="checkbox"/> YES
13. GENITO-URINARY DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
14. KIDNEY OR LIVER DISORDERS	<input type="checkbox"/> NO	<input type="checkbox"/> YES
15. MENTAL/NERVOUS/EMOTIONAL PERSONALITY DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES
16. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)	<input type="checkbox"/> NO	<input type="checkbox"/> YES
17. AIDS RELATED COMPLEX (ARC)*	<input type="checkbox"/> NO	<input type="checkbox"/> YES
18. EPILEPSY OR PARALYSIS	<input type="checkbox"/> NO	<input type="checkbox"/> YES

*ARC (AIDS RELATED COMPLEX) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.

I declare that I have completed this application form and that all answers and statements are true and complete to the best of my knowledge and belief. I agree that the Insurer may rely on them in acting on this application. I understand that no insurance may become effective unless approved by the Plan Administrator and if insurance for me and my dependents (if any) is approved, it will be subject to all the terms of the policies.

5. SIGNATURE OF APPLICANT _____ **DATE** _____

The signature of the applicant indicates that the applicant ONLY has fully completed this form and no other person has completed the questions.

RETURN THIS FORM TO:

Liberty Life Assurance Company of Boston
 Attn: Group Underwriting Department
 P.O. Box 1525
 Dover, NH 03821-1525