



**LIBERTY LIFE ASSURANCE COMPANY OF BOSTON  
EVIDENCE OF INSURABILITY FORM**

<b>EMPLOYER SECTION</b>	
Employer Name:	Group ID#:
Employer Address:	City: State: Zip:

**EMPLOYEE SECTION** Note: Please fill out this application completely as missing information will cause a delay in processing.

<input type="checkbox"/> Late enrollment <input type="checkbox"/> Employee only - STD <input type="checkbox"/> Employee only - LTD <input type="checkbox"/> Employee only - Life <input type="checkbox"/> Dependent(s) only - Life      Life Amount \$ _____ <input type="checkbox"/> Employee & Dependent(s) - Life <input type="checkbox"/> Additional Life coverage      Add'l Amount \$ _____ <input type="checkbox"/> Employee only <input type="checkbox"/> Dependent(s) only <input type="checkbox"/> Employee & Dependent(s) <input type="checkbox"/> Over non-medical maximum \$ _____ (amount over)	<input type="checkbox"/> Increasing coverage option during annual open enrollment <input type="checkbox"/> Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Family status change <input type="checkbox"/> Life <input type="checkbox"/> STD <input type="checkbox"/> LTD Check type of change below:      Family status change eff date: _____ <input type="checkbox"/> Employee's marriage/divorce <input type="checkbox"/> Spouse employment status change <input type="checkbox"/> Unpaid Leave by Employee <input type="checkbox"/> Employee employment status change or spouse <input type="checkbox"/> Birth/Adoption of child to Employee <input type="checkbox"/> Death of Employee's spouse/child <hr/> <input type="checkbox"/> Are you enrolling initially    OR <input type="checkbox"/> Increasing your coverage option
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<b>Employee</b>	PLEASE PRINT Employee Name	Social Security #	Date of Hire	
	Employee's Home Mailing Address	City	State	Zip
	Home Phone #	Annual Salary	Occupation	Date of Birth
	(____) - ____ - ____			Height    Weight    M/F

<b>Dependent</b>	Dependents by Name: (Only needed if applying for Dependent Life coverage)	Social Security No.	Relationship	Date of Birth	Height	Weight	M/F

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

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.

**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