Evidence of Insurability

For Group Coverage

ADVANCE Insurance Company of Kansas℠

Employer Name ______________________ Group Number ______________

Section 1 – Applicant (Employee) Information

First Name ______ MI ___

Last Name ______ Suffix ___

Social Security Number ___-___-_____

Height ___ ft. ___ in.

Weight _____

Phone Number (___) ___-_____

Your Medical Provider's Name ______

Provider's Mailing Address ______

City ______

State ___ ZIP Code ______

Phone Number (___) ___-_____

Approximate date of your last visit to your medical provider: ___ /___ /____ Date

Section 2 – Spouse Information – if you are applying to cover your spouse

First Name ______ MI ___

Last Name ______ Suffix ___

Date of Birth ___ /___ /____

Date of Marriage ___ /___ /____

Gender ☐ Male ☐ Female

Social Security Number ___-___-_____

Height ___ ft. ___ in.

Weight _____

Approximate date of your last visit to your medical provider: ___ /___ /____ Date

Spouse's Medical Provider's Name ______

Provider's Mailing Address ______

City ______

State ___ ZIP Code ______

Phone Number (___) ___-_____

Section 3 – Child Information – if you are applying to cover your (or your spouse's) child or children

Child 1:

First Name ______ MI ___

Last Name ______ Suffix ___

Relationship to Employee ______

Gender ☐ Male ☐ Female

Date of Birth ___ /___ /____

Height ___ ft. ___ in.

Weight _____

Child 2:

First Name ______ MI ___

Last Name ______ Suffix ___

Relationship to Employee ______

Gender ☐ Male ☐ Female

Date of Birth ___ /___ /____

Height ___ ft. ___ in.

Weight _____

Child 3:

First Name ______ MI ___

Last Name ______ Suffix ___

Relationship to Employee ______

Gender ☐ Male ☐ Female

Date of Birth ___ /___ /____

Height ___ ft. ___ in.

Weight _____

Please continue on the next page.

Section 3 – Child Information (continued)

Attention: If the physician shown at right is not the medical provider for all the children enrolling, you may use the blank space in Section 6 to give us the other providers' details. Print your name and Social Security number at the top of the page, provide complete information, and sign and date it.

Your Medical Provider's Name

Provider's Mailing Address

City

State ZIP Code

(_____) _____-________ Phone Number

Section 4 – Applicant(s) Health Information

Please check the boxes "yes" or "no." For each answer marked "yes," explain in the section(s) provided. (**NOTE:** If you run out of space, you may use the space in Section 6. Print your name and Social Security number at the top of the page, tell us which question you are answering, provide the requested information, then sign and date the response.)

Yes No

☐ ☐ 1. Is anyone applying for coverage currently pregnant?

Name of Pregnant Person | Expected Delivery Date | Physician Name, City and State

☐ ☐ 2. Is anyone applying for coverage currently hospitalized, bedridden due to disease, confined to a nursing facility, confined to a wheelchair, or receiving hospice or home health care services?

Name of Person Treated | Diagnosis or Details About Condition | Physician Name, City and State

☐ ☐ 3. Has anyone ever been diagnosed with, sought treatment by, or been recommended to have, an organ transplant by a medical professional?

Name of Person Treated | Diagnosis/Details of Condition and Medication Name/Dosage | Physician Name, City and State

4. In the past 5 years, has anyone been diagnosed with, treated for, or prescribed medication by a medical professional for:

☐ ☐ A. Heart or artery disorder, heart murmur or heart attack, tuberculosis, hepatitis, liver disease, stomach or intestine disorder, gastric bypass, kidney disorder, asthma, lung or other respiratory disorder?

☐ ☐ B. Cancer, leukemia, malignant growth or any form of tumor?

☐ ☐ C. Epilepsy, any nervous system disorder, alcoholism, drug abuse, substance abuse, Alzheimer's, dementia, progressive memory loss, bipolar disorder, schizophrenia, or any other mental illness?

☐ ☐ D. Back or spine injury, back pain, bone disease or disorder, osteoporosis, systemic lupus, joint pain, rheumatoid arthritis, carpal tunnel, chronic fatigue syndrome, fibromyalgia, or other musculoskeletal disorders?

☐ ☐ E. Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?

Explain any "yes" response(s) to Questions 4A through 4E:

Name of Person Treated	Diagnosis/Details of Condition and Medication Name & Dosage	Date Diagnosed	Date Last Seen	Physician or Pharmacy Name, City and State

Please continue on the next page.

Section 4 – Applicant(s) Health Information (continued)

Yes No

4. In the past 5 years, has anyone been diagnosed with, treated for, or prescribed medication by a medical professional for:

☐ ☐ F. High blood pressure?

Name of Person Treated	Medication Name & Dosage	Last Reading and Date	Next-to-Last Reading and Date	Physician or Pharmacy Name, City and State

☐ ☐ G. Diabetes, albumin, blood or sugar in the urine?

Name of Person Treated	Medication Name & Dosage	Age of Onset	How Controlled	Physician or Pharmacy Name, City and State

☐ ☐ 5. Have you or anyone requesting coverage been seen in the past five years by any type of medical (or mental health) doctor or practitioner – or presently under observation or receiving medical treament – for any reason or condition other than those listed in Questions 1 through 4?

Name of Person Treated	Diagnosis/Details of Condition and Medication Name/Dosage	Date Diagnosed	Date Last Seen	Physician or Pharmacy Name, City and State

Name of Person Treated	Diagnosis/Details of Condition and Medication Name/Dosage	Date Diagnosed	Date Last Seen	Physician or Pharmacy Name, City and State

☐ ☐ 6. Has anyone applying for coverage been declined, postponed or limited in any way for life, disability, health or accident insurance in the past five years?

Name of Person Treated	Type of Insurance	Declined, Postponed or Limited?	Reason

Section 5A – Important Information

I understand that I must sign below if I am applying for coverage. My signature verifies that I have read all the information on this form and represent that all statements made herein are complete and true to the best of my knowledge.

I understand Advance Insurance Company of Kansas (AICK) may correct premium, terminate, or rescind the policy: 1) if within two years of the policy effective date my answers are found to be incorrect; or 2) at any time, if the information provided herein intentionally misrepresents a material fact or was fraudulent.

I understand coverage is subject to the health of the Applicant remaining unchanged to the effective date of coverage. AICK's Underwriting Department must be notified of any such change prior to the effective date of coverage at (800)530-5989.

All persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A.

The insurance being applied for will become effective, subject to the terms and conditions of the policy for which application is made, the first day of the month following approval at the home office of AICK; an official contract issued and delivered; and the required premium paid to and accepted by AICK. If this application is not approved, no insurance will become effective.

The Applicant should not cancel any other coverage until notified by AICK that this application has been approved.

No agent or broker is authorized to bind coverage, approve applications, modify policies or alter or waive any rights or requirements of AICK.

A photographic copy of this authorization shall be as valid as the original.

I (1) request the coverage for which I am or may become eligible under the group policy or policies issued by AICK; (2) authorize the necessary payroll deductions, if any, from my earnings; (3) designate the beneficiary named on this form to receive the benefits, if any, payable in the event of death; (4) understand that among the requirements for continued eligibility is that I be a full-time active employee working the hours per week required for eligibility as stated in the group policy. I believe, to the best of my knowledge, the information which I have provided on this form is true and correct as it pertains to my status with the above employer.

Please continue on the next page.

Section 5B – Authorization for the Release of Protected Health Information

My signature authorizes any physician, medical practitioner or provider of services, hospital, clinic, pharmacy or other medically related facility, insurance, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition, and any other non-medical information about me to release, disclose and give to Advance Insurance Company of Kansas (AICK), or its reinsurers, a complete copy of any and all such information.

I understand that the information obtained by use of this Authorization will be used by AICK to determine eligibility for insurance and that my application for coverage may be delayed or denied if AICK is unable to obtain information necessary to do so.

I understand that information disclosed may no longer be protected and may be re-disclosed without further authorization. Note that AICK will not release information to any person or organization except to reinsurance companies or other persons, or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or further authorized.

I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will be effective to the extent that action has been taken in reliance upon this authorization or AICK otherwise has the right to contest the policy or claims under the policy.

I know that I, or my authorized representative, may request to receive a copy of this authorization. I agree that a photographic copy of the authorization shall be as valid as the original. I agree this authorization shall be valid for 24 months from the date shown below.

I understand I will be responsible for any fees or cost associated with the physical or for obtaining medical records for a late enrollee(s) in the insurance program.

Your signature required

Employee Signature ______________________ Date Signed ____ /____ /______

Print Name ______________________ Date of Birth ____ /____ /______

Spouse's signature required

Spouse Signature (if spouse is applying for coverage) ______________________ Date Signed ____ /____ /______

Print Name ______________________ Date of Birth ____ /____ /______

Signature of adult dependent child (over age 18) required

Adult Dependent Signature (if dependent over age 18 is applying for coverage) ______________________ Date Signed ____ /____ /______

Print Name ______________________ Date of Birth ____ /____ /______

Thank you for your application – Your group administrator will send this form to AICK

By fax: 785-290-0727

By mail: Advance Insurance Company of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

Questions? Call us at (800) 530-5989.

Please continue on the next page.

Section 6 – Additional Information

If you run out of space to respond to the questions in Sections 3 or 4, please use the blank space below. Print the employee's name and Social Security number where indicated below, tell us the question(s) you're answering, tell us who it applies to, provide the requested information, and **sign and date your response(s) below.**

First Name ____________ MI ____ Last Name ____________ Suffix ____

____-____-______
Social Security Number

Employee ____________________

____ / ____ / ______
Date Signed