

# Enrollment Form for Voluntary Group Life Insurance

## Evidence of Insurability Form

Amount of Life Insurance    Applicant \_\_\_\_\_ Spouse \_\_\_\_\_ Dependent \_\_\_\_\_     AD&D

This form must be completed by applicant to become eligible for the coverage under this group plan. If spouse is applying for insurance, all questions must be answered by spouse. I understand that this coverage becomes effective only if this application is accepted by Amalgamated Life Insurance Company.

Name of Policyholder \_\_\_\_\_ Group Policy # \_\_\_\_\_

### Employee/Member Information:

Date of Promotion \_\_\_\_\_ Date of Employment \_\_\_\_\_  Full time  Part Time  Retired: Retirement \_\_\_\_\_ Date of \_\_\_\_\_

1. Applicant Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone # \_\_\_\_\_ E-mail \_\_\_\_\_

Name of spouse \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Applicant: (a) Place of Birth \_\_\_\_\_ (b) Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Sex  M  F

Occupation \_\_\_\_\_ Annual Salary \_\_\_\_\_

Spouse: (a) Place of Birth \_\_\_\_\_ (b) Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Sex  M  F

Occupation \_\_\_\_\_ Annual Salary \_\_\_\_\_

### Beneficiary

FULL NAME	DATE OF BIRTH	RELATIONSHIP
Primary: (1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
Contingent: (1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____

Except as otherwise directed: (A) the proceeds are to be divided equally among all persons who are named as primary Beneficiary and who survive the insured, but if none survive, equally among all persons who are named as Contingent Beneficiary and who survive the insured, and (B) the right to change the beneficiary is reserved by insured unless otherwise noted.

### Medical Information

3. When was a doctor last consulted: (a) for Proposed Insured \_\_\_\_/\_\_\_\_/\_\_\_\_ (b) for Spouse \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Is any person to be insured now being treated or taking medicine for any condition or disease?.....  Yes  No      **APPLICANT**      **SPOUSE**  
 Yes  No       Yes  No
5. Has any person to be insured ever had, been told they had, or been treated for: Diabetes, Cancer, High Blood Pressure, Venereal Disease, Diseases or defects of the heart, blood, lungs, brain, kidneys, nervous or digestive systems?.....  Yes  No       Yes  No       Yes  No
6. Has any person to be insured consulted a physician for any reason during the last five years?.....  Yes  No       Yes  No       Yes  No
7. Has any person to be insured ever
- (a) been advised to have any diagnostic test, hospitalization or surgery which was not completed?.....  Yes  No       Yes  No
- (b) been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment?.....  Yes  No       Yes  No
- (c) been treated or counseled by a medical doctor for alcoholism or other drug dependency?.....  Yes  No       Yes  No
- (d) had life or health insurance declined, postponed, changed, rated-up or withdrawn?.....  Yes  No       Yes  No
8. Does any person to be insured have a known sign of any physical disorder, disease or defect not shown above?.....  Yes  No       Yes  No
9. Has any person to be insured been treated or diagnosed by a physician for any blood disorder or immune deficiency including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?.....  Yes  No       Yes  No
10. Are you actively at work? If not, when do you plan to return to work? Date \_\_\_\_\_  Yes  No       Yes  No
11. What are the full details of the answers to 3 through 10 which are answered "Yes"?

QUESTION # FOR APPLICANT	PLEASE LIST DOCTOR'S NAME AND ADDRESS AND ANY ADMISSION TO HOSPITAL. GIVE CAUSE AND REASON OF TREATMENT AND MEDICATION. IF ANNUAL CHECK-UP, PLEASE INDICATE ANNUAL ON FORM	DATES AND DURATION OF ILLNESS
QUESTION # FOR SPOUSE		