

INSTRUCTIONS FOR EVIDENCE OF INSURABILITY



Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

PART I:

PLEASE TYPE OR USE BLACK BALL POINT PEN. DO NOT USE CORRECTION FLUID. Please complete Part I in its entirety.

Evidence of Insurability is required for:

1. Late Enrollments -

A late enrollment occurs when an individual originally enrolls for health coverage only and requests life coverage at a later date.

2. Increasing Life Insurance Amounts.

Please mail these forms to:

Blue Shield of California Life & Health Insurance Company, P.O. Box 7725, San Francisco, California 94120-7725.

NOTE: Failure to accurately complete form will result in delayed processing!

PART II - IV:

Part II

Fill in name of individual for which Evidence of Insurability is required.

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

Part III & IV

Answer all health questions and give details in the space provided in Part IV only for "Yes" answers. Sign and date the form and detach Pre-Notice for your records.

PRE - NOTICE (remove for your records)

Cut 

Thank you for enrolling for Insurance with Blue Shield of California Life & Health Insurance Company (Blue Shield Life). As a part of the normal procedure of processing the application, information concerning the proposed insured(s) may be obtained for the purpose of determining insurability.

During the approval process, Blue Shield Life may collect personal information from persons other than the proposed insured and that under certain circumstances, information may be disclosed to third parties without authorization. You have a right of access and correction with respect to all personal information collected. A complete notice of information practices will be furnished upon request.

Information regarding your insurability will be treated as confidential. Blue Shield Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau ("the Bureau"), a non-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information contained in its file.

Upon receipt of your request, the Bureau will arrange disclosure of any information it contains in your file. If you question the accuracy of this information, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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 for benefits has been submitted.



EVIDENCE OF INSURABILITY INDIVIDUAL INSURANCE

PART I: FORM MUST BE TYPED OR COMPLETED IN BLACK BALL POINT PEN — PLEASE PRINT AND PRESS FIRMLY	For Blue Shield Life Use Only
<p>This enrollment form is for:</p> <p><input type="checkbox"/> New Coverage <input type="checkbox"/> Addition to Existing Coverage</p> <p><input type="checkbox"/> _____</p>	<p>Evidence Required Because:</p> <p><input type="checkbox"/> Late Enrollment</p> <p><input type="checkbox"/> Increasing Coverage</p>
<p>PLEASE COMPLETE BELOW:</p> <p><input type="checkbox"/> Amount Requesting _____</p> <p><input type="checkbox"/> Total Life _____</p> <p><input type="checkbox"/> Other \$ _____</p>	<p><input type="checkbox"/> APPROVED Eff. Date _____</p> <p><input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker</p> <hr/> <p><input type="checkbox"/> DECLINED</p> <hr/> <p>Date _____</p> <p>Reviewed by _____</p>

PART II: TO BE COMPLETED BY INSURED PERSON							
NAME - Last, First, Initial	SEX	SOCIAL SECURITY NUMBER	PHONE NO. / HOME / WORK	OCCUPATION	BASE ANNUAL EARNINGS		
HOME ADDRESS	<input type="checkbox"/> M <input type="checkbox"/> F				DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.
							WEIGHT

PART III: HEALTH QUESTIONNAIRE — Underline condition & record details in PART IV. If you are not sure about an answer, your physician will be able to provide you with this information.

<p>1. Have you ever received diagnosis or treatment for (CIRCLE CONDITIONS ANSWERED YES and explain in Section IV)</p> <p>A. Heart or artery disorder, heart attack, arthritis, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder, stomach and intestine? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B. High blood pressure? If Yes, last 2 readings and dates: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C. Diabetes, if diabetic, age of onset, how controlled? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>D. Cancer, Leukemia, malignant growth or any form of tumor? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>E. Epilepsy, or any Mental/Nervous disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>F. Paralysis and stroke? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>G. Alcoholism, drug, or substance abuse? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>H. a) Have you or any person applying been treated for or diagnosed with acquired immune deficiency syndrome (AIDS)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p> b) Hepatitis or any sexually transmitted disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Other than above, have you within the past five years had any physical disorder not listed above? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>3. Have you had any physical examinations in the last five years? (If "YES", give details in Section IV below regarding reason for exam, symptoms, treatment or medication and results). <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Are you</p> <p> A. Under observation or receiving treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p> B. Taking medication? (If "YES", list below) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Have you ever smoked? Packs a day? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p> How many years? If stopped, when?</p> <p>6. Have you ever been denied Life or Health Insurance? If yes, give date and reason <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Have you 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? If yes, please provide details, as well as your drivers license number and state of issue on reverse. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. Have you participated in any potentially hazardous sports or hobbies, such as Mountain Climbing, Scuba Diving, Sky Diving or Vehicle Racing (includes Auto, Motorcycle, Boat or other)? If yes, please provide details on reverse. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. Will this application replace any existing insurance coverage with this or any other carrier? If yes, please provide details on reverse. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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PART IV: Provide details of all "YES" answers given to questions in PART III. — If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name & Complete Address of Attending Physician or Other Practitioner

AGREEMENTS AND AUTHORIZATION: I have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand that Blue Shield Life shall not be liable for any claim on account of death or disability occurring or arising prior to the date of approval of this application at the Home Office of the Company. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or investigative reporting services that has any records or knowledge of me or my health, to give the Blue Shield Life or its reinsurers any such information, including drug or alcohol use or abuse, mental illness, AIDS, or other sexually transmitted diseases. This authorization is valid for 30 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received this Pre-Notice, and understand that coverage will not become effective until date of approval.

The applicant's failure to completely and correctly disclose his or her medical history, will result in the applicant's coverage being voided from the approval date of coverage.

Dated at _____, on _____

(CITY, STATE) (MONTH, DAY) (YEAR)

Signature _____