



APPLICANT HEALTH INFORMATION | EVIDENCE OF INSURABILITY

—Please Type Or Print Clearly In Dark Ink—

This form is only required if you are applying for Life and/or Disability coverage amounts over the Guaranteed Issue Limit, requesting an increase in coverage, applying more than 31 days after you were first eligible (a late applicant) or enrolling after having canceled coverage. Complete one form for each individual requesting coverage.

SECTION I | APPLICANT INFORMATION

Name of Employer:		Policy Number:	
Name of Employee (Last, First, MI):		Social Security Number:	
		Telephone Number:	
Street Address (Include Apt#/Suite):		City:	State: ZIP Code:
Name of Applicant: (Person Applying for Coverage) (Last, First, MI):		Place of Birth:	If Dependent, Relationship to Employee: <input type="checkbox"/> Spouse* <input type="checkbox"/> Child

BELOW CHECK THE APPLICABLE BOX(ES) TO INDICATE WHY YOU ARE COMPLETING THIS EVIDENCE OF INSURABILITY.

An amount over the Guaranteed Issue Limit	<input type="checkbox"/> Life	<input type="checkbox"/> Disability (Employee Only)
Coverage as a late applicant (or re-enrollment after cancellation)	<input type="checkbox"/> Life	<input type="checkbox"/> Disability (Employee Only)
An increase in existing coverage	<input type="checkbox"/> Life	<input type="checkbox"/> Disability (Employee Only)

SECTION II | NOTICE OF INFORMATION PRACTICES (Please read before completing the health information section.)

To properly underwrite your application for certain insurance coverages, we must collect information about you. We do this by having you complete the Health Information Section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including spouse, employer, medical professionals or institutions, and insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. Personal data may not include records relating to drug and alcohol treatment and psychotherapy notes.

We keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, with your written authorization, we may provide data to government agencies (e.g., an insurance department of your state), or attending physicians.

You have certain rights in connection with this request for coverage. You have the right to find out what personal information is contained in Renaissance Life & Health Insurance Company of New York (Renaissance) files (medical information may be disclosed only to your attending physician) and to correct or amend information in Renaissance files.

Upon written request, Renaissance will furnish to you (or your dependent) information concerning: the nature and scope of personal data in our records; the types of disclosures which may be made; and rights of access to the information collected and how such information may be corrected or amended.

Renaissance will not maintain information about HIV related test results pertaining to any individual unless such test results are included within a general code, which code is not designated solely for HIV related test results, and concerning which code no member of Renaissance may request from Renaissance details sufficient to determine whether the code was used to maintain information about HIV related test results.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact Renaissance Life & Health Insurance Company of New York, PO Box 1596 Indianapolis, IN 46206

**This Employee Enrollment Form uses the term "Spouse" to refer to the person, either Spouse or Domestic Partner, for whom you are applying for benefits. If your Employer does not extend benefits to Domestic Partners and you are not enrolling a Spouse, leave this section blank.*

SECTION III | HEALTH INFORMATION SECTION (Please read previous section prior to continuing)

1. Applicant: Male Female Height: _____ Weight: _____ Date of Birth (mm/dd/yyyy): _____

2. In the last 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any ailment or injury of the following organs, diseases or disorders below?

- A. High blood pressure, heart disease/disorder or chest pain? Yes No
- B. Cancer, Hodgkins disease, lymphoma or tumor? Yes No
- C. Diabetes, thyroid or endocrine disorder? Yes No
- D. Back, neck, joint or muscle disorder or injury? Yes No
- E. A disorder of the stomach, intestines, liver, gallbladder or rectum (*gastrointestinal disorder*)? Yes No
- F. A disorder of the kidney, bladder, prostate or reproductive organs (*genitourinary disorder*)? Yes No
- G. A respiratory or lung disorder or shortness of breath? Yes No
- H. A stroke or seizure? Yes No
- I. An emotional, mental or nervous condition? Yes No
- J. Alcohol or chemical dependency, or been convicted while driving under the influence of alcohol or drugs? Yes No
- K. An immune system or blood disorder? Yes No

3. In the last 10 years, have you been diagnosed or received treatment from a member of the medical profession for acquired immune deficiency syndrome (AIDS), lymphadenopathy syndrome or any other immune system disorder? Yes No

4. Have you been diagnosed, treated or advised by a member of the medical profession in the last 5 years for any condition not listed above? If yes, identify the condition here: _____ Yes No

5. In the last 5 years have you:

- A. Applied for insurance which was declined, postponed, modified, rated, canceled or denied renewal? Yes No
- B. Been advised to have any diagnostic test, hospitalization or surgery which was not completed? Yes No
- C. Taken prescription medication or been under treatment or observation by a medical practitioner? Yes No

6. Are you currently able to perform all the duties of your regular occupation, or if not employed, the duties of a person of like sex and age? Yes No

7. Are you now pregnant? If yes, anticipated delivery date (Mo/Yr) _____ Yes No

FOR ANY "YES" ANSWERS TO QUESTIONS 2-7, PROVIDE FULL DETAILS BELOW. YOU MAY OFFER ANY ADDITIONAL EXPLANATION YOU FEEL NECESSARY.

QUESTION # AND LETTER	SPECIFY ILLNESS OR CONDITION. INCLUDE DOCTOR'S ADVICE, TREATMENT, AND MEDICATION.	DATE CONDITION BEGAN MONTH/YEAR	TIME LOST FROM NORMAL ACTIVITIES	FULL RECOVERY (IF APPLICABLE) MONTH/YEAR

SECTION IV | AUTHORIZATION AND ACKNOWLEDGMENTS

By my signature below:

I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge and belief. They are a part of a request for coverage under the group policies and will be used by Renaissance to determine insurability.

I have read, or had read to me, the questions and responses and realize any material misstatements will cause this form and subsequent coverage to be contested subject to the incontestability clause of the Policy.

For the purpose of evaluating my application for insurance, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc., or other organization, institution or person that has any records or knowledge of me or my health, to give Renaissance or its reinsurers any such information. I also authorize Renaissance or its reinsurers to release any information regarding me or my health to the Medical Information Bureau, Inc., or other life insurance companies with which I have policies or to which I may apply, and other insurers to which a claim for benefits may be submitted. I understand that this information will be used by Renaissance to determine eligibility for insurance. This information includes information about drugs, alcoholism or mental illness. This authorization will be valid from the date signed for a period of 24 months and may be revoked by sending a written request to the Home Office. A photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The insurance requested with this Evidence of Insurability form will not be effective until approved by the Home Office of Renaissance. I hereby certify that I have received a copy of this form.

FRAUD WARNING (excluding Life Insurance): Any person, who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Employee (Required): _____ Date Signed: _____

Signature of Applicant (Required if at least 18 years of age): _____ Date Signed: _____

