Liberty Mutual

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
EVIDENCE OF INSURABILITY FORM
For Life Insurance

Please fill out this application completely. It will be returned to you if any information is missing.

1. EMPLOYER SECTION

Company Name	Group ID#	Location
Lee County Board of County Commissioners	05-291182	N/A

Company Address	City	State	Zip Code
2115 Second Street	Fort Myers	FL	33901

Current plan non-medical maximum	$250,000 Employee	$50,000 Spouse	$25,000 Child(ren)
Current plan overall maximum	Lesser of 10X BAE or $500,000 Employee	$250,000 Spouse	$25,000 Child(ren)

2. EMPLOYEE SECTION

A.) Application type: (Please check all that apply.)

- ☐ **First time coverage elected**
- ☐ **Increasing coverage amount**
- ☐ **Annual enrollment election**
- ☐ **Increasing above non-medical maximum**
- ☐ **Family Status Change:**
- ☐ **Effective date of change:** _____

Indicate Type of Family Status Change:

- ○ Employee marriage/divorce
- ○ Death of Spouse/Child
- ○ Unpaid leave by Employee or Spouse
- ○ Spouse employment status change
- ○ Employee employment status change
- ○ Birth/Adoption of child to Employee

B.) Coverage(s) Elected: Please see your Benefits Administrator with any questions. If amounts of coverage are not completed, the form will be returned to you.

- ☐ **Employee:**
  Current coverage amount $ _____ or _____ x salary
  Additional coverage applying for $ _____ or _____ x salary
- ☐ **Spouse:**
  Current coverage amount $ _____
  Additional coverage applying for $ _____
- ☐ **Child(ren):**
  Current coverage amount $ _____
  Additional coverage applying for $ _____

3. Employee Information (First Name, Last Name) (PLEASE PRINT)

Employee Name	Social Security No.	Date of Hire (mm/dd/yy)
	___ – ___ – ____	

Home Mailing Address	City	State	Zip Code

Home Phone ( )	Annual Salary	Occupation	Date of Birth	Height	Weight (lbs.)	M/F

4. DEPENDENT SECTION Please fill out this section completely as missing information will cause a delay in processing.

Dependent Information (Only needed if applying for Dependent Life coverage) (Spouse and/or Children) PLEASE PRINT

Dependent Name	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)

5.

1. Have any of the applicants had any application for life or health insurance declined, postponed or not approved as applied for?	☐ NO	☐ YES (if yes, provide the name to whom it applies, with full details and dates.)
2. Have any of the applicants ever been disabled?	☐ NO	☐ 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?	☐ NO	☐ 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?	☐ NO	☐ YES (if yes, provide the name to whom it applies, with full details and dates.)
5. Are any of the applicants currently pregnant?	☐ NO	☐ 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?	☐ NO	☐ 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	☐ NO	☐ YES
2. INTESTINAL DISORDER	☐ NO	☐ YES
3. RESPIRATORY DISORDER	☐ NO	☐ YES
4. HIGH OR LOW BLOOD PRESSURE	☐ NO	☐ YES
5. CANCER OR TUMORS	☐ NO	☐ YES
6. ULCERS	☐ NO	☐ YES
7. DIABETES	☐ NO	☐ YES
8. ALCOHOLISM	☐ NO	☐ YES
9. HEART DISEASE OR DISORDER	☐ NO	☐ YES
10. THYROID DISORDER	☐ NO	☐ YES
11. SUBSTANCE/DRUG ABUSE	☐ NO	☐ YES
12. STROKE OR CIRCULATORY DISEASE	☐ NO	☐ YES
13. GENITO-URINARY DISORDER	☐ NO	☐ YES
14. KIDNEY OR LIVER DISORDERS	☐ NO	☐ YES
15. MENTAL/NERVOUS/EMOTIONAL PERSONALITY DISORDER	☐ NO	☐ YES
16. HAVE YOU TESTED POSITIVE FOR EXPOSURE TO THE HIV INFECTION OR BEEN DIAGNOSED AS HAVING ARC OR AIDS CAUSED BY THE HIV INFECTION OR OTHER SICKNESS OR CONDITION DERIVED FROM SUCH INFECTION?	☐ NO	☐ YES
17. EPILEPSY OR PARALYSIS	☐ NO	☐ YES

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.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

6.

Employee Signature	Date	Spouse Signature	Date

RETURN THIS FORM TO:

Liberty Life Assurance Company of Boston
Attn: Group Underwriting Department
P.O. Box 1525
Dover, NH 03821-1525