

OFFICE USE ONLY		A _____ D _____ E _____
/ /	Employee Number	Coverage Code
Adjustment		

**Supplemental Evidence of Insurability Form**

Name of Company Where Employed		Date of F/T Employment / /		Job Title	Monthly Earnings	
Employee Name	Last	First		M.I.		
Employee Home Address			City	State	Zip	Home Phone ( ) -
Social Security Number	Date of Birth / /	Marital Status	Age	Sex	Height	Weight

**CONFIDENTIAL MEDICAL INFORMATION**

The following information is submitted as evidence of my insurability, if required.

- Have you in the past 10 years (other than for routine examination, check-ups, immunizations) consulted or been treated by a physician/practitioner, or been confined or treated in a hospital or similar institution, or been advised to have an operation which has not been performed or to enter a treatment program you are not currently receiving?  Yes  No
- Have you had or been told of, or consulted with a physician/practitioner for, or been treated for any of the following:  
High blood pressure, heart trouble or murmur, disorder of the blood or vessels; Alcohol or drug abuse; Tuberculosis; Kidney/bladder prostate or reproductive organs; Cancer, tumor, cyst or growth; Brain disorder; Spine, back disorder, chronic pain or fatigue, fibromyalgia, arthritis, rheumatism, gout, or any other bone, joint or muscle disorder; Diabetes, blood or sugar in the urine, thyroid or other glandular disorder; Mental or nervous disorder or epilepsy; Ulcer, colitis or other digestive system disorder; hernia or liver disorder (including hepatitis)?  Yes  No
- Have you:  
(a) received advice or treatment from a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No  
(b) been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No
- Are you under regular medical care or taking medication of any disease or disorder?  Yes  No

If you answered "yes" to any of the above health questions, please provide full details below. Include date of onset, diagnosis, all details of condition, routine exams, and names and addresses of Physicians and Hospitals. Attach an additional sheet if necessary.

Nature of Illness or Injury and Date and Duration of Medical Attention	Recovery Complete (Yes/No)	Names and Addresses Physicians/Hospitals

**FRAUD WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I'm applying to BEST Life and Health Insurance Company for supplemental group insurance coverage. The answers on this application, a copy of which will be a part of my insurance certificate if issued, are given to obtain this coverage. I hereby certify that I have read the statements contained on this application or that they have been read to me and that all statements made by me on this application are true and complete to the best of my knowledge and belief. I understand that misstatements or omissions in the application may be used to contest the validity of insurance, reduce coverage or deny a claim. I authorize my employer to deduct from my earnings any required contribution toward the premium. I further authorize any physician, hospital, clinic, insurer, or other organization or person having any records or knowledge concerning me to give this information to BEST Life and Health Insurance Company. A photocopy of this authorization will be as valid as the original.

I agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

Date: \_\_\_\_\_ Signature of Applicant **X** \_\_\_\_\_  
We pay all benefits according to the law of the State in which the policy was written.