

EVIDENCE OF INSURABILITY FORM



Life Insurance Company of North America (LINA)  
(herein called the Insurance Company)

For info and customer service call

- The applicant must sign and date this form.
  - This form cannot be considered unless received within 30 days of the date it is dated.
- Important: Please enter all dates in mm/dd/yyyy format.

PO Box 20310  
Lehigh Valley, PA 18003

**Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.**

Employer: \_\_\_\_\_ Policy: \_\_\_\_\_  
 Class: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Annual Salary: \_\_\_\_\_ Verified By: \_\_\_\_\_  
 Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) \_\_\_\_\_

VOLUNTARY COVERAGE	EMPLOYEE AMOUNT	SPOUSE* AMOUNT
1. Enter Requested Coverage Amount (Total)		
2. Enter Current Coverage including guarantee issue (enter zero if no current coverage)		
3. Subtract Line #2 from Line # 1, this is the amount subject to Underwriting		

**EMPLOYEE SECTION**

Employee Name (first, middle, last) \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ ID # \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender:  M  F

**COMPLETE IF ELECTING SPOUSE\* COVERAGE**

I am currently married and my date of marriage is: \_\_\_\_\_ -or-  I currently have an eligible Domestic Partner  
 Spouse\* Name: (first, middle, last) \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender:  M  F

**IMPORTANT**  
 Please complete each section that follows.  
 Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse information in this section if you (i.e., the Employee) or your spouse\* are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information									
Employee	Height	ft.	in.	Weight	lbs.				
				Spouse*	Height	ft.	in.	Weight	lbs.

Please indicate your answers for each question in this section by checking the Yes or No box for the question.

	Employee		Spouse*	
	Yes	No	Yes	No
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the conditions:				
A. A heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. HIV Infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

