



**APPLICATION FOR GROUP LIFE INSURANCE
EVIDENCE OF INSURABILITY
University of Wisconsin Employees, Inc.
Group Policy Number 46**

Name (First, Middle, Last)		Social Security Number	
Street Address		City	State Zipcode
Date of Birth (Mo/Day/Yr)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height/Weight	Date of Employment
Employer		Department Name	

MEDICAL HISTORY (If any questions are answered "yes," provide details below).

1. In the last 10 years have you been diagnosed with and/or received treatment for:

- a. Any disease or disorder of eyes, ears, nose, throat, mouth, or temporomandibular joint disorder? No Yes
 - b. Seizure, paralysis, headaches, dizziness, fainting spells, loss of consciousness, multiple sclerosis or any other disease or disorder of the brain or nervous system? No Yes
 - c. Chronic fatigue, stress, depression, anxiety or any other emotional or psychological disease No Yes
 - d. Asthma, allergies, tuberculosis, bronchitis, emphysema, sleep apnea or any other disease or disorder of the respiratory system? No Yes
 - e. High or low blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, aneurysm, varicose veins, high cholesterol or any other disease or disorder of the heart or circulatory system? No Yes
 - f. Ulcer, hernia, gastro esophageal reflux disease, hepatitis, cirrhosis or any other disease or disorder of the liver, gallbladder, pancreas, esophagus or digestive system? No Yes
 - g. Colitis, ulcerative colitis, polyps, Crohn's disease, irritable bowel, hemorrhoids or any other rectal or colon disease or disorder? No Yes
 - h. Any disease of the kidney, bladder, any blood or protein in the urine, prostate or testicular disorder, or any other disease or disorder of the urinary tract? No Yes
 - i. Endometriosis, infertility, abnormal pap smear or any other disease or disorder of the reproductive system including the uterus, fallopian tubes or ovaries, or breast disorder? No Yes
 - j. Diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the endocrine system? No Yes
 - k. Leukemia, anemia, or any other blood disease or disorder? No Yes
 - l. Back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, bursitis, neuritis, rheumatism or any other disease or disorder of the bones, joints or muscles? No Yes
 - m. Cancer, tumor, cyst, growth or disease or disorder of the skin or lymph glands? No Yes
 - n. Genital or rectal warts, herpes, condyloma or any other sexually transmitted disease? No Yes
- 2.** In the last ten years have you had, been treated for or been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome)? No Yes
- 3.** Are you currently pregnant or have you had complications of pregnancy in the last 10 years? No Yes
- 4.** In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or any other controlled substance? (If yes, explain below, including type, frequency and date of last use) No Yes
- 5.** Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? (If yes, explain below) No Yes
- 6.** Are you currently taking any medications? If yes, please list each medication, the dosage taken, the reason prescribed and full name and address of prescribing physician below. No Yes

Please list **date** of last medical treatment, **reason** for treatment, **final results** and the **name and address** of the doctor/clinic. If yes to questions 1-5, provide the following information – use additional paper if necessary.

Question #	Date(s)	Name of Disease, Injury or Operation	Name & Address of each Physician, clinic or hospital consulted and results.
Medications	Date(s) Taken	Name and dosage of Medication	Name & Address of prescribing Physician

**Agreement/Authorization
to Obtain and Disclose Information**

AGREEMENT

All Proposed Insureds and the Applicant, if other than the Proposed Insured, hereby consent to the insurance herein specified and state that the information in this application and any medical history is correctly recorded, complete and true to the best of their knowledge and belief:

HIPAA COMPLIANT AUTHORIZATION for Release of Health-Related Information

I AUTHORIZE any physician, practitioners, hospitals, clinics, other medically related facilities, the Medical Information Bureau, Inc. (MIB), my employer, consumer reporting agencies, insurance companies, and their reinsurers who may possess health and financial information about me or any of my children named in the application to release such information concerning me, my children, or another for whom I am legally authorized to sign to COUNTRY Life Insurance Company® and COUNTRY Investors Life Assurance Company®, and affiliates which are members of COUNTRY Insurance & Financial Service® (herein COUNTRY), its reinsurers, insurance support organizations, their authorized representatives, affiliates, and non-affiliated third parties as allowed by law. I authorize the release of medical, financial or any other personal information including information about health history, diagnosis, treatment, or prognosis with respect to any physical or mental condition including drugs, alcoholism, mental illness, or AIDS. Such information will be used by underwriters, medical professionals and other COUNTRY officers and employees to evaluate claims, life insurance and/or benefits applied for and other reasons necessary to facilitate my insurance transaction. The information may be shared with affiliates and unaffiliated third parties as allowed by law and as necessary to facilitate my transaction. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records to any agency employed by COUNTRY to collect and transmit such information. I further authorize MIB to transmit any relevant information to any agency employed by COUNTRY.

I UNDERSTAND that this authorization is valid for (24) months from the date it is signed and a photocopy and/or fax is also valid, except for the disclosure of AIDS information in which case it is valid for 180 days.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

This authorization may be revoked in writing by contacting the Home Office of COUNTRY Life Insurance Company or COUNTRY Investors Life Assurance Company. Revocation of this authorization does not extend to actions COUNTRY has already taken in reliance upon the authorization or the right of COUNTRY to use information to contest a claim under the policy or the policy itself.

Issuance of this policy is conditioned upon COUNTRY Life Insurance Company and COUNTRY Investors Life Assurance Company, and affiliates which are members of COUNTRY Insurance & Financial Services receiving a fully and effectuated authorization. COUNTRY cannot commence its underwriting process and issue a policy unless you sign the authorization. We strive to keep your private information confidential. However, if at any time you disclose private information, you bear the risk that it may be inadvertently redisclosed and no longer protected by federal, state or local law.

I acknowledge receiving a copy of the notice regarding Insurance Information Practices, the Medical Information Bureau, Inc., consumer and/or investigative consumer reports, and medical record information. I, or my legal representative, may receive a copy of this authorization upon request.

I, the parent or legal guardian, give my consent to this application on the child's life. I agree that any policy issued may be under the absolute control of the applicant. It shall be understood that said applicant may designate anyone he/she desires as beneficiary and may exercise any and all rights of the policy without my consent.

Signature of Insured	Date
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Send Completed Form to:

COUNTRY Life Insurance Company
Central Regional Office
PO Box 64035
St. Paul, MN 55164
(800) 345-2436