SYMETRA
RETIREMENT | BENEFITS | LIFE

EVIDENCE OF INSURABILITY FOR GROUP COVERAGE

Group Policy No. 01-016500-00

Company Name (Employer)	**COVERAGES REQUESTED:**
Company Address	☐ Supplemental Life (total) $_____
City State ZIP	Supplemental Life (in-force) $_____
Name of Employee Date of Hire	☐ Supplemental Spouse Life (total) $_____
Job Title Basic Annual Earnings	Supplemental Spouse Life (in-force) $_____
Home Address	☐ Supplemental Child Life (total) $_____
City State ZIP	Supplemental Child Life (in-force) $_____
Home Phone ( ) _____ **Work Phone** ( ) _____	

HEALTH INFORMATION (INCLUDE ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE)

NAME	RELATION-SHIP	SEX	DATE OF BIRTH Mo/Day/Yr	STATE OF BIRTH	HT. Ft	HT. In	WT.	FULL NAME AND ADDRESS OF PERSONAL PHYSICIAN
1.	EMPLOYEE							
2.	SPOUSE							
3.								
4.								

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are any applicants pregnant? ☐ Yes* ☐ No
   ***If yes, please give details on the next page including due date.**
2. Are any applicants currently taking any medication? ☐ Yes* ☐ No
   ***If yes, please give details on the next page.**
3. In the past ten years, or as indicated below, have any of the applicants been treated for, or been diagnosed by a member of the medical profession as having any of the following: ☐ Yes* ☐ No
   ***If yes, please indicate condition and provide details on the next page.**

a) ____ Heart Disorder, Chest Pain, Circulatory Disorder
b) ____ High Blood Pressure
c) ____ Mental & Nervous Disorder, Depression
d) ____ Alcoholism and/or Drug Habits
e) ____ Stomach, Abdominal, Intestinal Disorder
f) ____ Brain or Nervous System Disorder
g) ____ Stroke, Paralysis
h) ____ Cancer, Tumors
i) ____ AIDS or HIV Infection/Disease
j) ____ Reproductive Organ Disorder
k) ____ Sexually Transmitted Disease
l) ____ Kidney Disorder
m) ____ Liver Disorder
n) ____ Gland Disorder
o) ____ Diabetes
p) ____ Developmental Disorder
q) ____ Epilepsy, Seizures
r) ____ Birth Defect
s) ____ Lungs, Respiratory Disorder
t) ____ Bone, Joint, Connective Tissue Disorder
u) ____ Accident or Injury
v) ____ Blood Disorder
w) ____ Infectious Diseases
x) ____ Back, Neck Pain, or Discomfort

4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ***If yes, please indicate condition and provide details on the next page.**
   ☐ Yes* ☐ No

IMPORTANT: PLEASE SIGN AND DATE ON THE NEXT PAGE

HEALTH INFORMATION

Question # Or Letter	Name of Person	Details of Yes Answers	Onset Mo. Yr.	Duration	Degree of Recovery	Full Name and Full Address of Attending Physician

Please read the following notice that we are required by law to give you.

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

CALIFORNIA: For your protection California law requires the following to appear: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FLORIDA: 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Signature of Employee:_____Print Name:_____Date:_____

Signature of Spouse:_____Print Name:_____Date:_____

(if applying)

SYMETRA
RETIREMENT | BENEFITS | LIFE

Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient