LINCOLN LIFE ASSURANCE COMPANY OF BOSTON
EVIDENCE OF INSURABILITY FORM
For Disability Insurance Coverage

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
Company Address	City	State	Zip Code

2. EMPLOYEE SECTION

A.) Coverage(s) Elected:

☐ **Short Term Disability (STD) (Employee Only)**

☐ **Long Term Disability (LTD) (Employee Only)**

B.) Application Type (Please check all that apply):

☐ First time coverage elected
☐ Increasing coverage amount
From: _____ To: _____
☐ Annual enrollment election

Please see your Benefits Administrator with any questions.

☐ 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

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
( )						

This section requires complete answers for all applicants (dependent information only necessary if applying for Dependent Life coverage)

4.

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. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)	☐ NO ☐ YES
17. AIDS RELATED COMPLEX (ARC)	☐ NO ☐ YES
18. 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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **(Not Applicable to Accident & Health.)**

5. SIGNATURE OF APPLICANT _____ **DATE** _____

The signature of the applicant indicates that the applicant ONLY has fully completed this form and no other person has completed the questions.

RETURN THIS FORM TO:

Medical Underwriting
Lincoln Financial Group
PO Box 2870
Omaha, NE 68103-2870