

# MONUMENTAL LIFE INSURANCE COMPANY

## Evidence of Insurability for Group Insurance

Name of Employee (First, Middle, Last) Please Print \_\_\_\_\_

Date of Birth (Mo., Day, Yr.) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ State of Birth \_\_\_\_\_  
ft. inches lbs.

Occupation \_\_\_\_\_

1. Have your activities been to any extent restricted or limited during the past 3 months on account of sickness or injury? .....  Yes  No
2. Do you have any mental or physical defects, impairment of vision or hearing? .....  Yes  No
3. Do you contemplate, or have you ever been advised to have, any hospital treatment or surgical operation? .....  Yes  No
4. Name below all causes or reasons for which, during the past 5 years, you have been under observation, care or treatment, for which you have consulted a physician or practitioner or have been referred to a physician including insurance examinations, employment examinations and routine annual check ups. Give dates of any electrocardiographic or x-ray examinations. If none, so state. If questions 1, 2, or 3, are answered "Yes", give details below.

Condition	Number of Occasions	Date Mo. & Yr.	Duration	Any remaining effects	Any Operation	Name and Address of Hospital and Attending Physician

5. Are you now in good health? (if "No", explain)  
 Yes  No

6. Has any application for insurance on your life ever been declined, postponed or rated up? ((If "Yes", give details)  
 Yes  No

I declare the foregoing statements and answers are complete and true to the best of my knowledge and belief.

I hereby acknowledge receipt of a notice that an "Investigative Consumer Report" may be made on any person proposed for insurance in connection with this application, and receipt of a notice concerning the "Medical Information Bureau."

I hereby authorize any physician, practitioner, hospital, clinic, insurance company, or other organization or person that has any record or knowledge of me or my health to give to the Monumental Life Insurance Company or its representative any such information. I also authorize the Medical Information Bureau to give any such information to the Monumental Life Insurance Company. A photographic copy of this authorization shall be as valid as the original.

Street and Number \_\_\_\_\_

Signature of Employee \_\_\_\_\_

City and State \_\_\_\_\_

Date Signed \_\_\_\_\_

### Employer's Statement

Name of Employee (Print or Type) \_\_\_\_\_

Date of Employment \_\_\_\_\_

	Life	*Acc. D. & Dism
Amount of Insurance		

1. Is the employee actively at work on a full time basis and able to perform all his duties? .....  Yes  No  
If "No", Explain \_\_\_\_\_

2. Do you know of any reason why the employee would not be a satisfactory risk for coverage under your group plan? .....  Yes  No  
If "Yes", why? \_\_\_\_\_

Name of Policyholder \_\_\_\_\_

Branch or Plant Location \_\_\_\_\_

**Kentucky Transportation Employees Association**

Date \_\_\_\_\_

By (Signature and Title) \_\_\_\_\_

### This Space to be Completed by Insurance Company

Last Day Eligible Without Evidence \_\_\_\_\_

Group Policy No. \_\_\_\_\_

Certificate No. \_\_\_\_\_