



LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

EVIDENCE OF INSURABILITY FORM
DISABILITY COVERAGE

University
of
California

EMPLOYER SECTION	
Employer Name: UCM	Group ID #: 60-037972
Contact Name:	Contact Phone Number:

EMPLOYEE SECTION	
(Please fill out completely. Application may be delayed by missing information.)	
<input type="checkbox"/> Application for late enrollment	<input type="checkbox"/> Change in waiting period from ___ to ___ days
Employee Name:	Date of Hire:
Employee Address:	City: State: Zip:
Social Security No.:	Date of Birth: Height: M/F: Weight:

This section requires complete answers for all applicants.

1. Within the last 3 years, have you consulted or been attended or examined by any doctor or other practitioner or been a patient in any hospital, clinic or similar institution?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide names and explanations)
2. Are you currently taking medications, prescribed or otherwise?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide names and explanations)
3. Are you currently pregnant?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide names and explanations)

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 you now under treatment for, or have you ever had or been told you had, any diseases or symptoms in any of the following areas:
(If YES, give names, dates and full details)

1. BACK OR SPINAL	<input type="checkbox"/> NO <input type="checkbox"/> YES
2. INTESTINAL	<input type="checkbox"/> NO <input type="checkbox"/> YES
3. RESPIRATORY	<input type="checkbox"/> NO <input type="checkbox"/> YES
4. HIGH OR LOW BLOOD PRESSURE	<input type="checkbox"/> NO <input type="checkbox"/> YES
5. CANCER OR TUMORS	<input type="checkbox"/> NO <input type="checkbox"/> YES
6. ULCERS	<input type="checkbox"/> NO <input type="checkbox"/> YES

PLEASE COMPLETE REVERSE SIDE ALSO

7. DIABETES	<input type="checkbox"/> NO <input type="checkbox"/> YES
8. ALCOHOLISM	<input type="checkbox"/> NO <input type="checkbox"/> YES
9. HEART DISEASE, MURMUR or other symptoms	<input type="checkbox"/> NO <input type="checkbox"/> YES
10. THYROID	<input type="checkbox"/> NO <input type="checkbox"/> YES
11. SUBSTANCE/DRUG ABUSE	<input type="checkbox"/> NO <input type="checkbox"/> YES
12. STROKE OR CIRCULATORY DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES
13. GENITO-URINARY	<input type="checkbox"/> NO <input type="checkbox"/> YES
14. KIDNEY OR LIVER	<input type="checkbox"/> NO <input type="checkbox"/> YES
15. MENTAL/NERVOUS/EMOTIONAL symptoms	<input type="checkbox"/> NO <input type="checkbox"/> YES
16. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) <i>California law prohibits an HIV test from being used by health insurance companies as a condition of obtaining health insurance coverage.</i>	<input type="checkbox"/> NO <input type="checkbox"/> YES
17. AIDS RELATED COMPLEX (ARC)	<input type="checkbox"/> NO <input type="checkbox"/> YES
18. EPILEPSY OR PARALYSIS	<input type="checkbox"/> NO <input type="checkbox"/> 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 is approved, it will be subject to all the terms of the policies.

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: Liberty Life Assurance Company of Boston
Attn: Group Underwriting Department
100 Liberty Way
P. O. Box 1525
Dover, NH 03821-1525