Liberty Mutual

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

EVIDENCE OF INSURABILITY FORM
DISABILITY COVERAGE

University of California

EMPLOYER SECTION			
Employer Name:		Group ID #: 037972	
Employer Address:	City:	State:	Zip:
Contact Name:	Contact Phone Number:		

EMPLOYEE SECTION **(Please fill out completely. Application may be delayed by missing information.)**

☐ Application for late enrollment ☐ 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?	☐ NO ☐ YES (if yes, provide names and explanations)
2. Are you currently taking medications, prescribed or otherwise?	☐ NO ☐ YES (if yes, provide names and explanations)
3. Are you currently pregnant?	☐ NO ☐ 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	☐ NO ☐ YES
2. INTESTINAL	☐ NO ☐ YES
3. RESPIRATORY	☐ NO ☐ YES
4. HIGH OR LOW BLOOD PRESSURE	☐ NO ☐ YES
5. CANCER OR TUMORS	☐ NO ☐ YES
6. ULCERS	☐ NO ☐ YES

PLEASE COMPLETE REVERSE SIDE ALSO

7. DIABETES	☐ NO ☐ YES
8. ALCOHOLISM	☐ NO ☐ YES
9. HEART DISEASE, MURMUR or other symptoms	☐ NO ☐ YES
10. THYROID	☐ NO ☐ YES
11. SUBSTANCE/DRUG ABUSE	☐ NO ☐ YES
12. STROKE OR CIRCULATORY DISEASE	☐ NO ☐ YES
13. GENITO-URINARY	☐ NO ☐ YES
14. KIDNEY OR LIVER	☐ NO ☐ YES
15. MENTAL/NERVOUS/EMOTIONAL symptoms	☐ NO ☐ YES
16. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) *California law prohibits an HIV test from being used by health insurance companies as a condition of obtaining health insurance coverage.*	☐ 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 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