



Our Interest is You.

Evidence of Insurability

Bermuda Life Insurance Company Limited

Group Life Insurance Group LTD Insurance Group Health Insurance

A. Applicant Information

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Miss		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
Mailing Address		Country of Residence	
Cell Phone	Work Phone	Home Phone	Email
Applicant's Relationship to Employee	If other than self, Employee Name	Marital Status	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated/Divorced <input type="checkbox"/> Widowed	
Weight (lbs.)	Height (ft. in.)	Occupation (State day to day activities)	Nationality

B. Name of Employer of the Employee

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C. Statement of Health of Applicant

Please answer every question. If any question is answered 'yes' also complete Section E. (Use separate forms for dependents.)

<p>1. Have you ever had, sought advice for, or been told you have any:</p> <p>a. cardiovascular disease or disorder such as stroke, angina, heart disease, high blood pressure, circulatory problems, chest pains, TIA or varicose veins? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. respiratory disease or disorder such as lung disease, chronic cough, shortness of breath, asthma, tuberculosis, pleurisy, emphysema, sleep apnea or bronchitis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. urinary, kidney, prostate, bladder disease or disorder or any disease or disorder of the reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. gastrointestinal disease or disorder such as ulcer, colitis, diarrhoea, rectal bleeding, digestive problems, hepatitis, hepatitis carrier or liver disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. neurological disease or disorder such as dizzy spells, fainting, epilepsy, paralysis, recurrent headaches, fits or seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. arthritis, rheumatism, gout, neck or back problems, disc disease, joint or bone disorders including sprains and strains, chronic fatigue syndrome and fibromyalgia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. diabetes, sugar in urine or thyroid disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. any difficulties with eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. H.I.V., A.I.D.S., A.I.D.S. related conditions or immunological disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. treatment for drug use, stress, anxiety, depression or any other mental or psychiatric problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. disease or disorder of the skin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. disease or disorder of the blood including anaemia or haemophilia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>m. cancer, tumour, cyst, polyp or any other growth or malignancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>n. enlargement of lymph nodes, glands, unusual or persistent skin lesions or unexplained infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>o. illness, personal injury, birth defect, congenital defect, disease or disorder not mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>p. any disease or disorder of the breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you had an increase or decrease in weight of 10 lbs. or more in the past 12 months? If yes, then indicate details in Section D <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>3. Have you ever been advised by a physician to stop drinking or to drink less or had any treatment for alcohol abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. Indicate average weekly amount of alcohol consumed: Beer _____ wine _____ spirit _____</p> <p>4. During the last 10 years have you:</p> <p>a. had or been advised to have surgical procedures, special examinations or laboratory tests, blood transfusions, or been treated in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. used cocaine, heroin or other narcotics, marijuana, LSD, or amphetamines, except as prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. In the past 5 years, have you been absent from work for more than 5 consecutive days, due to illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. During the past 12 months, have you smoked cigarettes, cigars, pipe or used chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently receiving medical treatment by diet, medicine or other means? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever received a pension, disability benefit or compensation for any accident or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you engage, or have you ever engaged, or do you have any intention or prospect of engaging in hazardous sports including but not limited to scuba diving, kite surfing, sky diving, motor, vehicle, motorcycle or boat racing, or flying other than as a passenger on regularly scheduled flights? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you ever been refused life, disability or health insurance, or had it offered on special terms, with modifications or had insurance cancelled? If 'yes' state type of policy: Rated <input type="checkbox"/> Declined <input type="checkbox"/> Exclusions <input type="checkbox"/> Postponed <input type="checkbox"/> Cancelled <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Have you any intention or prospect of residing or traveling outside your country of residence other than on a vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Are there any pending tests, investigations or surgeries which have not yet occurred or do you have any symptoms or complaints for which you have not yet consulted a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. If the applicant is female:</p> <p>a. are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. have you ever had any complications of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Name of regular attending Physician	Address
Date of last visit (MM/DD/YY)	Reason for visit
	Results

D. Current Insurance Coverage

If you or your spouse have any other health insurance policy, please complete the following information:

Name of Insured	Policy Date (MM/DD/YY)	Policy Number
Type of Insurance	Name of Insurance Company	

E. Additional Details

Complete this section for any questions answered 'yes' in Section C. If additional space is required, please attach a separate sheet, and date and sign each sheet.

Question	Date of Occurrence	Description (e.g. treatment received, name and address of physician or hospital, etc.)

F. Special Notice

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

G. Declaration

I certify that the statements on both sides of this form, and on any attached sheet, are true and complete to the best of my knowledge and belief, and that no material information has been withheld or suppressed. I agree that this document and all its contents will form part of my enrolment for the insurance applied for. This information may be used by the Insurer to decide whether I am eligible for coverage.

I authorise the Insurer to exchange such information as may be required for underwriting, administration and claims payment, with any person or organisation which has relevant personal information about me (including other insurers, medical practitioners and institutions), and persons who perform insurance functions or medical services for the Insurer. I understand that the Insurer will not be responsible for the payment of any fee charged for providing such information.

A photocopy or facsimile of this authorisation is as valid as the original.

Applicant's Signature (Parent or Guardian if Child)

Date (MM/DD/YY)

For Argus Use Only

Approved By	Effective Date (MM/DD/YYYY)	Date (MM/DD/YYYY)

Remarks: