



## 5. HEALTH INFORMATION FOR LIFE INSURANCE COVERAGE

**YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION:** Louisiana law prohibits insurance companies from requiring genetic testing, disclosure of genetic test results or disclosure of prenatal test results.

**IMPORTANT NOTICE:** Any omissions or misstatements in this application may void your coverage or cause an otherwise valid claim to be denied.

- Is anyone named in this application
  - currently taking any medications prescribed by a physician? (If yes, please list all medications below) .....  Yes  No
  - now disabled or unable to perform normal work- or age-related activities? .....  Yes  No  
(If yes, please identify names, conditions and dates of disability below.)
- Has anyone named in this application had a professional medical diagnosis of Acquired Immune Deficiency Syndrome(AIDS) or AIDS Related Complex (ARC)? (We are not seeking the results of HIV Antibody Test) .....  Yes  No
- Within the last five years, has anyone named in this application been advised or scheduled to have surgery or tests not yet completed? .....  Yes  No
- Within the last 10 years, has anyone named in this application been seen, counseled, consulted, or treated for:

**Yes No**

- Heart Disease/Disorder, Stroke, Circulatory Disorder, or High Blood Pressure
- Diabetes or Connective Tissue Disorder
- Asthma, Emphysema or Lung Disease or Disorder

**Yes No**

- Ulcers, Stomach or Intestinal Disorder
- Cancer, Tumor or Abnormal Growth
- Nervous or Psychological Disorders
- Liver Disorder

**Yes No**

- Kidney, Bladder or Prostate Disorder
- Anemia or Blood Disorder
- The Use of Alcohol, Chemicals, or Other Drugs (Been Advised to Cease or Decrease Use of)

IN THE SPACES BELOW, PLEASE LIST MEDICATIONS AND PROVIDE FULL DETAILS TO QUESTIONS FOR WHICH YOU ANSWERED "YES" ABOVE. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

QUESTION NO.	FAMILY MEMBER	DATES OF TREATMENT	DATE OF FULL RECOVERY	IDENTIFY THE CONDITION AND TYPE OF TREATMENT RECEIVED	NAME/ADDRESS OF ATTENDING PHYSICIAN/HOSPITAL

## 6. DISCLOSURES, AUTHORIZATION AND SIGNATURE

If applicable, I authorize my employer to make deductions from my earnings for my share of the cost of the coverage to which I am entitled.

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until: the Administrator approves this application, eligibility requirements have been met, and certificate of insurance is issued, which shall not be valid unless the first period cost is paid. I further understand that this application will become a part of my certificate and any coverage afforded will be in consideration of the answers being true and complete and the premium paid. I also understand that any misstatements or failure to provide sought for information may be used as the basis for rescission of my insurance.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, government agency, insurance company or other organization or person, that has any records or knowledge of me or any family member for whom insurance is requested, to give CBSA, Jefferson Pilot Financial Insurance Company or their representative(s) any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_

## 7. WAIVER OF INSURANCE

If you wish to waive coverage for yourself and/or your dependents, please complete this section and sign below.

Employee Name \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

### #1 Employee's Refusal of:

- Life Insurance  
for:  myself  my spouse  my child/ren

### #2 Reason for Refusal:

- Insured under another plan  
 Contribution required  
 Other (list explanation) \_\_\_\_\_

I hereby certify that I have been given an opportunity to apply for insurance under the Group Insurance policy or policies provided by my employer, and that I have declined to do so.

I understand that by not applying for such insurance, I will not become insured under said policy or policies and will not be entitled to any benefits thereunder.

I further understand that if I and/or my dependents desire to apply for such insurance at a later date, coverage may possibly not be available or I may be required to provide health status information. Depending on applicable law, coverage may possibly not be issued.

Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_