Evidence of Insurability Statement

Life Coverage

Aetna Life Insurance Company

Make a copy for your records.
Mail the original to:
Aetna Life Insurance Company
Medical Underwriting Department
PO Box 83641
Lincoln, NE 68501-3641
Customer Service: 1-800-660-9913

Fax to (Applications within the US): 1-800-792-9710 **Fax to (International Applications Only): 1-402-474-8426**

A. Plan Sponsor: Complete this Section - Please print.

1. Control Number	Suffix	Account	2. Employee/MemberSocial Security Number
100527	011		

3. Plan Sponsor Name & Address	4. Employee/Member Name & Address
Tulsa Firefighter's Health and Welfare Trust	
ATTN: Gail Harris	ATTN:
Name 6100 S. Yale, Avenue, Suite 1900	Name
Street	Street
Tulsa OK 74136	
City State ZIP Code	City State ZIP Code

5. Plan Sponsor - Authorized Rep. Telephone Number	6. Employee/Member Date of Hire (MM-DD-YY)	7. Employee/Member Telephone Numbers
(918) 359-6198		Work ( ) Home ( )

8. Plan Sponsor E-mail address	9. Employee/Member E-mail Address
gharris@theholmesorg.com	

10. Employee/Member's Annual Earnings $ _____

11. Coverage(s) Applied for:

☐ Life* ☐ Employee/Member Basic Life ☐ Employee/Member Supplemental, Optional or Voluntary Life
☐ Spouse ☐ Child(ren)

	Employee/Member Basic Life	Employee/Member Supplemental, Optional or Voluntary Life	Spouse Life	Child(ren) Life
a. **Current** Amount of Life Insurance Coverage?	$	$	$	$
b. **Additional** Amount of Life Insurance Coverage requested?	$	$	$	$
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$	$	$	$
d. **Guarantee Issue** Amount of Life Insurance?	$	$	$	$

***Reason for Requested Coverage (indicate all that apply).**

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Increments ☐ Life Event/Status Change
☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Limit ☐ Other (Please explain) _____

12. I certify the above information is correct.

Plan Sponsor - Authorized Representative Signature | Plan Sponsor - Authorized Representative Name (Please print) | Date Signed (MM/DD/YYYY)

B. Employee/Member: Complete this Section - Please print. ***All questions must be answered. Incomplete forms cannot be processed.***

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate *(MM/DD/YYYY)*	Birthplace (City/State)	Gender	Height (ft., in.)	Weight (lbs.)
Employee:	Self					
Spouse:						
Child(ren):						

2. Complete these questions if dependent children are listed above. ***Use Number 4 if additional space is needed.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household? If No, please explain: _____
b.	☐	☐	Do all dependent children depend solely on you for support? If No, please explain: _____
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school? If No, please explain: _____

B. Employee/Member: Complete this Section - Please print. (Continued)

3. Statement of Health for Individual(s) Listed Above. Please answer the following questions to the best of your knowledge and belief. If any of the following questions are checked "Yes", you must provide details in Number 4 below.

	Yes	No	
a.	☐	☐	Is any individual pregnant? If Yes, Who: _____ Date Due: _____ Any complications or problems: _____
b.	☐	☐	Has any individual used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)? If Yes, Who: _____
c.	☐	☐	Are any inpatient or outpatient medical, surgical or diagnostic procedures recommended or contemplated: If Yes, When: _____ Individual: _____ Name of procedure: _____ Reason for procedure: _____
d.	☐	☐	In the past 7 years has any individual been confined to a hospital, clinic, sanatorium, rehabilitation or other treatment facility? If Yes, Who: _____ Why: _____ When: _____
e.	☐	☐	In the past 7 years has any individual been examined, monitored or received medical treatment from any doctor, practitioner or counselor for any condition other than minor illnesses (cold, flu, etc.)? If Yes, Who: _____ Why: _____ When: _____
f.	☐	☐	Is any individual(s) currently taking medication(s)? If Yes, complete the following information:

Name of Individual	Medication	Dosage/Frequency	Diagnosis

g. Within the past 10 years have you, your spouse or child(ren) had any disease, impairment of or treatment (other than minor illnesses) for any of the following? If Yes, check the appropriate box(es) and describe in *Number 4*.

☐ AIDS*	☐ Cancer	☐ Immune System Disorder	☐ Nervous System
☐ Arthritis	☐ Carpal Tunnel Syndrome	☐ Intestine/Stomach/Ulcer	☐ Paralysis/Paresis
☐ Asthma/Emphysema/COPD	☐ Chest Pain	☐ Kidney/Bladder	☐ Reproductive System
☐ Back/Spine/Neck	☐ Chronic Fatigue/Fibromyalgia	☐ Liver/Spleen/Pancreas	☐ Skin Disorder
☐ Blood Disorder/Bleeding/Blood Clot	☐ Diabetes/Metabolic	☐ Lungs/Breathing	☐ Stroke
☐ Blood Pressure/Hypertension	☐ Ears/Eyes	☐ Lupus	☐ Substance Abuse (Alcohol/Drug)
☐ Blood Vessels/Circulation	☐ Epilepsy/Seizure	☐ Mental/Emotional Condition	☐ Throat/Tonsils/Swallowing
☐ Bones/Joints	☐ Esophagus/Digestion/GERD	☐ Multiple Sclerosis	☐ Thyroid/Pituitary/Adrenal
☐ Brain	☐ Heart	☐ Muscular Condition	☐ Tumor/Growth

☐ **Other** _____

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

4. In the space below, describe all conditions checked in 3g above and provide additional information for questions 2a-c and 3a-f, if needed.

Ques. No.	Name of Individual	Diagnosis	Date of Onset	Details/ Symptoms	Treatments Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my Plan Sponsor's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for twelve (12) months from the date signed. **I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee/Member's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (Required if spouse coverage is requested)	Date