Individual Assurance Company, Life, Health & Accident 930 E. 2nd Street, Suite 100 Edmond, OK 73034

EVIDENCE OF INSURABILITY

GROUP NUMBER: _____ **EMPLOYEE – SPOUSE – CHILDREN**

GROUP DIVISION: _____ Amount of Insurance: $ _____

Full Name: _____ Occupation: _____
Last First Middle

Residence Address: _____
Street and Number City State Zip Code

State of Birth: _____ S.S.#: _____ ☐ Married ☐ Divorced ☐ Single ☐ Legally Separated

Name of Employer: _____ Dept/Branch: _____ Date Employed: _____

	Name	Date of Birth	Age	Height	Weight	Sex
Employee:						
Spouse:						
1st Child:						
2nd Child:						

HEALTH STATEMENT OF EMPLOYEE AND DEPENDENT(S)

The following questions must be answered for each person listed above; Employee, Spouse, and Child. Attach additional forms if needed.

		Employee		Spouse		1st Child		2nd Child	
1.	Have you ever been treated for, or diagnosed as having, any of the following conditions:	Yes	No	Yes	No	Yes	No	Yes	No
	a. any disease or disorder of the heart or circulatory system?	☐	☐	☐	☐	☐	☐	☐	☐
	b. cancer, diabetes, stroke, or lung disorder?	☐	☐	☐	☐	☐	☐	☐	☐
	c. liver or kidney disease?	☐	☐	☐	☐	☐	☐	☐	☐
	d. AIDS or tested positive for HIV?	☐	☐	☐	☐	☐	☐	☐	☐
	e. alcohol or drug abuse?	☐	☐	☐	☐	☐	☐	☐	☐
2.	Have you, within the past 12 months, consulted a physician or clinic for any reason?	☐	☐	☐	☐	☐	☐	☐	☐

Provide details for each question answered "Yes" in the space below. If more space is needed, use the reverse side of this form.

Name	Condition (Diagnosis)	Dates Treated	Results of Treatment (Recovered?)	Full Name & Address of Physicians Consulted

It is understood and agreed that all statements in this application are true to the best of my/our knowledge and belief, and are offered as a consideration for and shall become a part of any policy issued hereon. I/we understand and agree that the insurance is not in force until I am notified by Individual Assurance Company, Life, Health & Accident (IAC) that I have been approved and accepted by IAC. I/we acknowledge receipt of the Preliminary Notification attached hereto in compliance with federal law. To determine my/our insurability, I/we hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me/us or my/our health, to give to the underwriters of IAC or its reinsurers' underwriters any such information. This authorization is valid for 24 months from the date signed. I/we may revoke this authorization at any time by providing written notice to IAC. Upon request, I/we, or any person authorized to act on my/our behalf, are entitled to receive a copy of this authorization. A photographic copy of this authorization shall be as valid as the original.

_____ _____ _____
Witness Signature Proposed Insured Signature Date

_____ _____
Spouse Signature Date

APPLICATION WILL BE RETURNED UNLESS ALL QUESTIONS ARE ANSWERED.
INSURANCE WILL NOT BE IN FORCE UNTIL THE APPLICATION IS APPROVED BY THE COMPANY.

PRELIMINARY NOTIFICATION IN COMPLIANCE WITH FEDERAL LAW

This is to inform you that as part of our routine underwriting procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. Information regarding your insurability will be treated as confidential. INDIVIDUAL ASSURANCE COMPANY, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB,) a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866-692-6901 (TTY 866-346-3642). INDIVIDUAL ASSURANCE COMPANY or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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