



LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
EVIDENCE OF INSURABILITY FORM
For Life and Disability Insurance

Please fill out this application completely. It will be returned if any information is missing.

1. EMPLOYER SECTION			
Company Name: Stanford Hospital and Clinics		Group ID#: 60-039040	
Company Address: 300 Pasteur Drive		City: Stanford	State: CA
		Zip Code: 94305	
New hire non-medical maximum for life insurance:	Lesser of: 3 x Base Salary, or 600,000 Employee	50,000 Spouse/Domestic Partner	
Family Status Change - non-medical maximum for life insurance:	1 x Base Salary Employee	50,000 Spouse/Domestic Partner	
Current plan overall maximum for life insurance:	1,000,000 Employee	200,000 Spouse/Domestic Partner	

2. EMPLOYEE SECTION		
A) Application Type: <input type="checkbox"/> New Hires - First time coverage selected over non-medical maximum amount (see above) <input type="checkbox"/> Increasing coverage above non-medical maximum <input type="checkbox"/> Family Status Change - increasing coverage above non-medical maximum (see above)	B) Disability Coverage(s) Elected: <input type="checkbox"/> Short Term Disability (STD) (Employee Only) <input type="checkbox"/> Long Term Disability (LTD) (Employee Only)	C) Life Coverage(s) Elected: (Please see your Benefits Administrator with any questions.) If amounts of coverage are not completed, the form will be returned to you. <input type="checkbox"/> Employee: Level of coverage applying for: <input type="checkbox"/> 1 x Salary <input type="checkbox"/> 2 x Salary <input type="checkbox"/> 3 x Salary <input type="checkbox"/> 4 x Salary <input type="checkbox"/> Spouse/Domestic Partner: Amount of coverage applying for: \$ _____ (The lesser of 50% of the employee's approved amount or \$200,000)

3. EMPLOYEE INFORMATION (First Name, Last Name) (PLEASE PRINT)						
Employee Name			Employee ID		Date of Hire(mm/dd/yy)	
Home Mailing Address			City	State	Zip Code	
Home Phone # ()	Annual Salary	Occupation	Date of Birth	Height	Weight	M/F

4. DEPENDENT SECTION Please fill out this section completely as missing information will cause a delay in processing.					
Dependent Information (Only needed if applying for Spouse/Domestic Partner Life Coverage)			PLEASE PRINT		
Name	Relationship	Date of Birth	Height	Weight	M/F

This section requires complete answers for all applicants (dependent information only necessary if applying for Dependent Life coverage)

5. 1. Have any of the applicants been unable to work due to sickness or injury or perform regular activities for more than 7 consecutive days in the past 5 years?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
2. Within the last 3 years, have any of the applicants consulted or been attended or examined by any doctor or other practitioner or been a patient in any hospital, clinic or similar institution?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
3. Are any of the applicants currently taking medications, prescribed or otherwise?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
4. Are any of the applicants currently pregnant?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)
5. Have any of the applicants used tobacco in any form in the last 12 months?	<input type="checkbox"/> NO <input type="checkbox"/> YES (if yes, provide the name to whom it applies, with full details and dates.)

Name and address of physicians consulted _____

PLEASE COMPLETE REVERSE SIDE ALSO

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 any of the applicants now under treatment for, or have had or been told they had within the past five years, any of the following diseases or symptoms: **(If YES, provide the name to whom it applies, with full details and dates.)**

1. BACK OR SPINAL DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
2. INTESTINAL DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
3. RESPIRATORY DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
4. HIGH OR LOW BLOOD PRESSURE	<input type="checkbox"/> NO <input type="checkbox"/> YES
5. CANCER OR TUMORS	<input type="checkbox"/> NO <input type="checkbox"/> YES
6. ULCERS	<input type="checkbox"/> NO <input type="checkbox"/> YES
7. DIABETES	<input type="checkbox"/> NO <input type="checkbox"/> YES
8. ALCOHOLISM	<input type="checkbox"/> NO <input type="checkbox"/> YES
9. HEART DISEASE OR DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
10. THYROID DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
11. SUBSTANCE/DRUG ABUSE	<input type="checkbox"/> NO <input type="checkbox"/> YES
12. STROKE OR CIRCULATORY DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES
13. GENITO-URINARY DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
14. KIDNEY OR LIVER DISORDERS	<input type="checkbox"/> NO <input type="checkbox"/> YES
15. MENTAL/NERVOUS/EMOTIONAL PERSONALITY DISORDER	<input type="checkbox"/> NO <input type="checkbox"/> YES
16. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)	<input type="checkbox"/> NO <input type="checkbox"/> YES
17. AIDS RELATED COMPLEX (ARC)	<input type="checkbox"/> NO <input type="checkbox"/> YES
18. EPILEPSY OR PARALYSIS	<input type="checkbox"/> NO <input type="checkbox"/> 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 and my dependents (if any) 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
P.O. Box 1525
Dover, NH 03821-1525