WEAtrust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

Group Life Insurance Evidence of Insurability

Note: Not to be used for Medical Coverage

Please type or print in black ink only.

1. Group Policyholder Information

Employer's Name: _____ Group No.: _____
Employee's Name: _____ Social Security No.:_____
Occupation: _____
Employee's Address: _____
Street City State Zip Code

2. Employee Information (to be completed by employee)

Complete for each person applying for insurance at this time.

Name	Relationship	Male/Female	Height	Weight	Date of Birth	Full-time Student Yes/No
	Self					
	Spouse					
	Child					
	Child					
	Child					

3. Has any person proposed for coverage ever had or been treated for or consulted a physician or other medical professional about any of the following:
   a. Epilepsy, brain, or nervous system disorder; mental, nervous, or emotional disorder? ☐ Yes ☐ No
   b. Respiratory or lung disorders, tuberculosis, hay fever, asthma, bronchitis, emphysema? ☐ Yes ☐ No
   c. Diabetes, kidney disorders, gland or genitourinary tract disorder? ☐ Yes ☐ No
   d. Stomach, intestine, rectal disorder, abdominal pain, ulcer disorder, appendix, liver, or gall bladder disorder, hernia? ☐ Yes ☐ No
   e. Arthritis: lupus, rheumatism or gout; back, spine, or skeletal system disorder; bone, Muscle, or joint disorder? ☐ Yes ☐ No
   f. Cancer, tumor, growth, or cyst, goiter or thyroid disorder? ☐ Yes ☐ No
   g. Congenital defect or disorder, accidental injuries? ☐ Yes ☐ No
   h. Disorder of the reproductive organs, breast disorder, fertility problems, venereal disease, complications of pregnancy? ☐ Yes ☐ No
   i. Impairment in sight, speech, hearing, eye, ear, nose, or throat disorder? ☐ Yes ☐ No
   j. Heart or circulatory system disorder, high blood pressure, chest pains, stroke, heart murmur, rheumatic fever, phlebitis? ☐ Yes ☐ No
   k. Alcoholism, drug dependency, or substance abuse? ☐ Yes ☐ No
   l. Disorder of the blood or lymph nodes? ☐ Yes ☐ No

4. Has any person proposed for coverage been diagnosed or treated by a member of the medical profession for an immune system disorder or for AIDS or ARC? ☐ Yes ☐ No

5. To the best of your knowledge, other than admitted to in Question #3, has any person for whom application is being made including yourself, spouse, and any dependents been examined or treated by a medical practitioner, undergone a surgical procedure, or been hospitalized (including pregnancy) in the past five years? ☐ Yes ☐ No

6. Do you or anyone proposed for coverage plan to visit a medical practitioner or have an operation for any existing injury or illness? ☐ Yes ☐ No

7. During the past 12 months, have you or any proposed insured had any medical consultation, advice, or treatment by a medical practitioner, had medication prescribed, had surgery, or been confined in a hospital, psychiatric, or school and drug dependency facility (inpatient or outpatient), or been advised by a medical practitioner, that a hospital confinement, and/or surgery will be needed during the next six months? ☐ Yes ☐ No

8. Has any person proposed for coverage ever been declined, postponed, rated, or limited for life or health insurance? ☐ Yes ☐ No

9. Have you or your spouse smoked cigarettes, cigars, pipes, or used tobacco in any form during the past 12 months? ☐ Yes ☐ No
   If Yes, amount per day _____ ; and for how long _____

10. Is any person proposed for coverage now pregnant? ☐ Yes ☐ No
    If Yes, approximate due date? _____

For any questions answered "Yes" in items 3 through 8, please supply the following information, and be as specific as possible.

Question Number	Peron's Name	Condition, Injury, or Symptom of Ill Health (Name of operation performed)	Date of Onset	Date Last Treated	Results/Prognosis (List current medications and dosages)

Agreements

The answers and statement on this application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by WEA Trust at its home office.

I have read, or have had read to me, the completed application, and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract.

Medical Authorization

I authorize any of the following to disclose to WEA Trust, Madison, WI, any data it has on me or my health or on the health of my family: (1) any physician or other medical practitioner; (2) any hospital, clinic, or other medical-related facility; (3) any insurance company; (4) the Medical Information Bureau; or (5) any other organization, institution, or person that has data on me or my health or on the health of my family. I specifically authorize the release of information on alcohol or drug abuse and mental illness. I also authorize such disclosure of data to the reinsurer of WEA Trust. I waive, to the extent allowed by law, all provisions of law forbidding such disclosure. I make such waiver on behalf of myself and any person who shall have or claim any interest on any insurance issued hereon. A copy of this shall be as valid as the original.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete, or misleading information may be guilty of insurance fraud, which is a crime.

Investigative Consumer Reports Notification

In compliance with Public Law 91-508, an investigative consumer report may be made within the next few days which will provide applicable and relevant material concerning character, general reputation, personal characteristics, and mode of living of any persons to be covered. This report will be obtained through personal interviews with friends, neighbors, and associates. Upon written request to the Company, a complete and accurate disclosure of the nature and scope of the investigative consumer report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. WEA Trust or its reinsurers may, however, make a brief report to MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901.

WEA Trust 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.

IMPORTANT

All fees for doctor's statement or examination are the responsibility of the applicant. WEA Trust assumes no responsibility for payment of such fees.

Please return this completed form to your Benefits Administrator at the following address.

WEA Trust
PO Box 51538
Eagan, MN 55121-5038

X _____ _____
Signature of Employee/Applicant Date