



EMPLOYEE MEDICAL EVIDENCE OF INSURABILITY & APPLICATION

Application to Guarantee Trust Life Insurance Company, Glenview, IL

May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.

Electronic copies of this application submitted via facsimile, email, or other electronic means shall be deemed an original.



SECTION 1 – APPLICANT INFORMATION

FULL NAME OF EMPLOYEE		MARITAL STATUS	SEX	HEIGHT	WEIGHT	ADM. Use Only	
RESIDENCE ADDRESS		CITY	STATE		ZIP	CASE NO.	
TELEPHONE NUMBER (include area code)		Best time to contact (if additional information is required by Insurance Company)				EMPLOYEE NO.	
AGE (last Birthday)	BIRTHDATE (mm/dd/yy)	DATE BEGAN FULL TIME (mm/dd/yy)		SOCIAL SECURITY NUMBER			CLASS
EMPLOYED BY		EMPLOYERS PHONE (include area code)		AVG. NO. HOURS WORKED WEEKLY	MONTHLY EARNINGS	\$	EFFECTIVE DATE
EMPLOYER'S LOCATION – STREET ADDRESS		CITY	STATE	ZIP			OCC YES <input type="checkbox"/> NO <input type="checkbox"/>
OCCUPATION AND DUTIES			LIFE INSURANCE BENEFICIARY AND RELATIONSHIP				UWF 48 YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____
<input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER							
I Am Applying for (check one): <input type="checkbox"/> SELF ONLY; <input type="checkbox"/> SELF AND SPOUSE; <input type="checkbox"/> SELF AND CHILD(REN) <input type="checkbox"/> SELF, SPOUSE, & CHILD(REN)							
I Am Applying for (check all that apply): <input type="checkbox"/> ALL BENEFITS <input type="checkbox"/> LIFE INSURANCE							
						UWF 40 YES <input type="checkbox"/> NO <input type="checkbox"/>	HEALTH YES <input type="checkbox"/> NO <input type="checkbox"/> ADD LIFE YES <input type="checkbox"/> NO <input type="checkbox"/>

If you have dependents (spouse and/or children) and have chosen not to include any dependents in this coverage, please complete the following:
I AM NOT APPLYING FOR DEPENDENT COVERAGE BECAUSE (check one):
 Covered by another group/individual health plan. Other (explain) _____
 I understand, that if I have dependents and do not make application at this time, I may be forfeiting certain rights as described on the reverse under Applicant Statement. I understand that I have the right to apply for coverage at this time. I am voluntarily declining dependent coverage and have not been induced or pressured by anyone to decline coverage.

DEPENDENT INFORMATION						ADM. USE ONLY				
Complete for spouse and each dependent child to be insured. (use additional sheet if necessary)										
NAMES OF DEPENDENTS	REALTIONSHIP	HEIGHT	WEIGHT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MUW	MHX	LAT	D&R	PXT
EMPLOYEE NAME	SELF									
1.										
2.										
3.										
4.										
5.										

SECTION 2 – PRIOR INSURANCE COVERAGE CREDIT

Have you or your dependents been covered under any health insurance plan within the last 90 days? YES NO
 If Yes, to qualify for prior coverage credit, please provide the following information on all coverage inforce in the past 12 months – Please note that most of this information can be obtained from your current Insurance Identification Card:

Name of Insurance Company _____ Ins. Co. Phone Number () _____

Effective date of Prior Coverage* _____ Termination Date _____

Type of Coverage (i.e. employer sponsored or individual) _____ Policy/Cert. Number _____

Coverage was for (check all that apply): Myself Spouse Children

**We need confirmation of your coverage with your prior carrier. Please provide us with a copy of the Certificate of Credible coverage provided by the carrier.*

Please complete information & sign on reverse.

