

NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. **North Carolina Mutual Life Insurance Company** may, however, make a brief report thereon to the 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, the Bureau, upon request, will supply such company with the information in its file.

North Carolina Mutual Life Insurance Company may also make information in its files available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

NOTICE TO PROPOSED INSURED

In order to properly underwrite and administer your insurance coverage, we must collect certain necessary and helpful information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish), items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment or deletion of information you believe to be inaccurate.

Send to:
 North Carolina Mutual Life Insurance Company
 411 West Chapel Hill Street
 Durham, NC 27701
 Attn: Group Life Claims

Evidence of Insurability

Attention			Type of Insurance		Hire Date
Name of Group/Administrative Office			Beneficiary Relationship		Account Number
Street Address			Beneficiary (Life Coverage Only)		
City			Coverage		Amount of Life/DI Coverage Applied for
State			<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Dependent(s) <input type="checkbox"/> Dependent Only		
Zip Code			Optional Life Coverage Current Annual Salary	Current Voluntary Life Coverage	Requested Option

I. Application For Coverage

Employee	SSN#	Tel ()	Date of Birth	Birth State
Street Address	City		State	Zip Code
Spouse's Name	Spouse's Social Security Number		Date of Birth	Birth State
Child's Name	Child's Social Security Number		Child's Date of Birth	
1	1		1	
2	2		2	
3	3		3	

II. Employee and Dependent Statement of Health (supply information only for insured and/or dependent(s) to be covered)

1. Employee's: Height	Weight	1a. Spouse's: Height	Weight	2. Have you or any of your dependents ever had any life or health insurance postponed, rated, rideder, declined, canceled or had reinstatement refused? If yes, give dates, company name and reason in remark section below. <input type="checkbox"/> Yes <input type="checkbox"/> No
3. To the best of your knowledge and belief, have you or any of your dependents ever been medically treated for or medically advised of any of the following:				
a. Epilepsy, or any nervous, mental or emotional disorder?				<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Abnormal blood pressure, heart attack, heart murmur; any other blood, heart or circulatory disorder, or any immune deficiency disorder?				<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Any lung or respiratory disorder?				<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Ulcer of the stomach or duodenum, any rectal disorder, gall bladder or any other digestive disorder?				<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Kidney or any other urinary disorder, albumin, pus or sugar in urine, disorder of the prostate or genital organs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Thyroid disorder, diabetes, gout, any eye or ear disorder, any discolored areas or lesions of the skin or mouth?				<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Arthritis, rheumatism, any disorder of the back, spine, neck, bones, muscles or joints?				<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Cancer, tumor, growth, enlarged lymph nodes or any skin disorder?				<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Alcoholism, drug dependency or substance abuse?				<input type="checkbox"/> Yes <input type="checkbox"/> No
4. To the best of your knowledge and belief, have you or any of your dependents in the last 5 years ever had any medical advice or treatment, physical impairment, deformity, sickness, operation, injury or check-up other than admitted in question 3, or are you or any of your dependents pregnant at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. To the best of your knowledge and belief, do you or any of your dependents now carry any Disability Income, Major Medical, Hospital, Surgical insurance or Service Plan or have any application pending for such insurance or plan? If yes, give company name, types of coverage and amounts in remarks section below. <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Are you currently working your regular work week? If no, explain in remarks section below. <input type="checkbox"/> Yes <input type="checkbox"/> No				
7. Please complete the following for each "yes" answer to questions 3 and 4.				

Question #	Person	Medical Condition	Treatment	Dates	Results	Doctors or Hospitals (Names and Addresses)

Remarks: Questions 2, 5 and 6 (If additional space is needed, use a separate sheet, sign, date and return it with this form.)

I AGREE that the statements and answers contained in parts I and II, are complete and true.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, employer or the Veterans Administration, having information available as to advice, diagnosis, treatment or care of any physical or mental condition concerning me, my spouse or my minor children, including information about drugs, alcoholism or mental illness, and/or any other non-medical information concerning me, my spouse or my minor children to give to **North Carolina Mutual Life Insurance Company**, its legal representative or its reinsurers, any and all such information.

I UNDERSTAND the information obtained by use of this Authorization will be used by **North Carolina Mutual Life Insurance Company** to determine eligibility for insurance.

I KNOW that I may request to receive a copy of this Authorization.

I ACKNOWLEDGE having received and read the Notice Regarding Medical Information Bureau and the Notice of Insurance Information Practices (where applicable).

I AGREE that a copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall remain valid for two years from the date shown below.

Date _____ Employee's Signature _____

FOR INSURANCE COMPANY'S USE ONLY

Coverage Approved For	Additional Information	Effective Date of Insurance
<input type="checkbox"/> Employee <input type="checkbox"/> Dependent/s	<input type="checkbox"/> Medical <input type="checkbox"/> Doctor's Statement	<input type="checkbox"/> Declined <input type="checkbox"/> Postponed
Effective the first of the insurance month coinciding with or next following	<input type="checkbox"/> Form Not Complete	
Signed _____ Title _____	Signed _____ Title _____	Signed _____ Title _____