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

Group Life Insurance Evidence of Insurability

Note: Not to be used for Medical Coverage

Please print clearly and in black ink only.

Section 1: EMPLOYER INFORMATION	
Employer's Name:	Group Number:
Section 2: EMPLOYEE INFORMATION	
Employee's Legal Name:	
Social Security Number:	Employee's Occupation:
Employee's Street Address:	
Employee's City:	
Employee's State and Zip Code:	

Complete for each person applying for insurance coverage this time.

Section 3: Height, Weight, and Full-time Student Status

Legal Name	Relationship	Gender Assigned at Birth	Height	Weight	Is this Dependent Disabled? Yes/No	Full-time Student? Yes/No
	Self				N/A	N/A
	Spouse					N/A
	Child					
	Child					
	Child					
	Child					

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Answer for each person applying for insurance coverage this time.

Section 4: Underwriting Questions			
1.	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. Alzheimer's disease, Dementia, Amyotrophic Lateral Sclerosis (ALS), Parkinson's disease, multiple sclerosis (MS), muscular dystrophy (MD), or mental health disease/disorder (not including treated/or controlled depression)?	☐ Yes	☐ No
	b. Respiratory or lung disorders, COPD (Chronic Obstructive Pulmonary Disease), pulmonary sarcoidosis, shortness of breath (SOB), require the use of home oxygen (this does not include a CPAP/BPAP machine) or emphysema?	☐ Yes	☐ No
	c. Insulin-dependent diabetes, kidney disease, require ongoing kidney dialysis treatment, end stage renal disease or disease of the pancreases (other than non-insulin dependent diabetes)?	☐ Yes	☐ No
	d. Ulcerative Colitis?	☐ Yes	☐ No
	e. Cancer (other than Basal Cell), Leukemia, Hodgkin's Disease, Lymphoma, unexplained anemia, tumors, and/or masses?	☐ Yes	☐ No
	f. Heart or circulatory system disorder, cardiomyopathy, congestive heart failure (fluid around the heart), heart enlargement, cardiac arrest, heart attack (myocardial infraction), irregular heartbeat, abnormal heartbeat (arrhythmia), chest pain (angina), uncontrolled high blood pressure (hypertension) (other than controlled by physician's or other medical professional's advice), peripheral vascular disease (PVD), stroke (CVA), or any blockage or narrowing of the arteries?	☐ Yes	☐ No
	g. Liver disease, cirrhosis, Hepatitis B or C, or alcoholic liver disease?	☐ Yes	☐ No
	h. Alcoholism, drug dependency, or substance abuse?	☐ Yes	☐ No
2.	Has any person proposed for coverage been diagnosed or treated by a member of the medical profession for or tested positive for Human Immunodeficiency Virus (HIV) infection Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐ Yes	☐ No
3.	In the last 5 years, has any person proposed for coverage been institutionalized or hospitalized for a psychiatric or mental health disease or disorder?	☐ Yes	☐ No
4.	Has any person proposed for coverage received or is waiting to receive an organ transplant?	☐ Yes	☐ No
5.	Is any person applying for coverage currently bedridden, confined to a wheelchair, receiving home healthcare services, staying in a nursing home, or receiving medical assistance at an assisted living facility?	☐ Yes	☐ No
6.	Has any person proposed for coverage ever been declined, postponed, rated, or limited for life or health insurance?	☐ Yes	☐ No
7.	In the past 3 years, has any person proposed for coverage participated in or intending to participate in the next 2 years any of the following activities: scuba diving deeper than 130 feet; skydiving; parachuting, racing, including car, motorcycle, or boat; base jumping; or free diving to depths greater than 50 feet?	☐ Yes	☐ No

Section 4: Underwriting Questions Continued		
8.	In the past 3 years, has any person proposed for coverage participated in or intending to participate in the next 2 years flying other than a passenger on a scheduled airline?	☐ Yes ☐ No
9.	For applicants 0-14 years of age, has any person proposed for coverage ever been diagnosed with a congenital disorder?	☐ Yes ☐ No

For any question answered "Yes" in the sections above, please provide the following information:

Section 5: "Yes" answer information	
Question(s) Number	**Person's Name**

Please read, sign, and date below.

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 enrollment form and Group Life Insurance Evidence of Insurability form, and I realize that any false statements or misrepresentation may result in loss of coverage under the contract.
Upon approval of this enrollment form and Group Life Insurance Evidence of Insurability form, I hereby authorize payroll deduction from my earnings.
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 and may be subject to penalties under state law.
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:		
WEA Trust Attn: Life Insurance Department PO Box 21538 Eagan, MN 55121-5038	**By Fax:** Attn: Life Insurance Department (608) 276-9119	**By Secure Upload:** https://www.weatrust.com/secure-file-upload#

x _____ _____

Signature of Employee/Applicant Date