MAINE SERVICE EMPLOYEES ASSOCIATION INCOME PROTECTION PLAN & TRUST
5 Community Drive, Augusta, Maine 04330
(207) 622-3151 / (207) 621-1475 (FAX)

EVIDENCE OF INSURABILITY

Office Use Only

Accepted ☐
Denied ☐
Date _____
Initials _____

NAME _____

ADDRESS _____ CITY _____ ST ____ ZIP _____

SOC SEC # _____ DATE OF BIRTH _____

DATE OF HIRE _____ DATE ELIGIBLE (if different) _____

CHECK ONE: LATE ENROLLMENT ☐ INCREASE IN BENEFIT COVERAGE ☐

COMPLETE ALL QUESTIONS

Height _____ft _____in Weight _____lbs Waist Size _____in Gender: M ____ F ____

	Yes	No
1. Have you ever applied for insurance which was declined, postponed, rated, or modified in any way?	☐	☐
2. During the past five (5) years, have you:		
A. Been treated for or advised of any sickness, disease, injury, physical, mental or psychological impairment?	☐	☐
B. Consulted or been examined or treated by a physician, practitioner or specialist?	☐	☐
C. Been in a hospital, sanitarium, clinic or other institution for observation, diagnosis, treatment, or an operation?	☐	☐
D. Been advised to have treatment or observation in a hospital or clinic or been advised to have a surgical operation?	☐	☐
If so, was it done?	☐	☐
3. On the back of this form, you must list the name, address and phone # of your Primary Care Physician. Also list, if applicable, your Gynecologist, Mental Health Provider, or any Specialist that you may have seen within the last 5 years.		
4. Are you now pregnant? (Circle) Yes No If yes, expected date of delivery is _____		
5. Are you now under regular medical observation or taking medication?	☐	☐
6. To the best of your knowledge and belief, are you now in good health and free from any and all physical, mental and psychological impairments or diseases?	☐	☐

IF ANSWERS TO 1,2 (A through D) OR 5 ARE YES, IDENTIFY THE NUMBER AND EXPLAIN MEDICAL HISTORIES IN TERMS OF:

Please feel free to use the back of the form or an additional sheet, if needed, to fully answer the questions.

A) Dates, duration, and number of attacks and/or episodes.

B) Describe all symptoms.

C) How did the physician define the condition? (Diagnosis?)

D) What treatment, therapy, prescription or advice was given?

E) Describe fully any special examinations, x-rays or laboratory tests that may have been performed and state results, if known to you.

F) Date all treatment was discontinued or date of complete cure. _____

ALL QUESTIONS MUST BE ANSWERED AND DETAILS PROVIDED FOR ANY "YES" ANSWERS OR THE FORM WILL BE RETURNED

I hereby certify that the statements above are true to the best of my knowledge and belief, and I agree that they shall form a part of the contract of insurance applied for and I authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any records or knowledge of me to give the Plan and its Administrators any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be as valid as the original. I hereby acknowledge that the Maine State Employees Association Income Protection Plan does not provide benefits for absences arising out of work-related accidents or illnesses. I hereby certify that I have retained a copy of this form.

_____ _____
Signature Date

NOTE: Any misrepresentation or omission of material in this statement will result in a rescission of coverage and loss of benefits.

**** RETURN THE COMPLETED FORM TO THE INCOME PROTECTION PLAN AT THE ADDRESS ON THE TOP OF THIS FORM ****