



EVIDENCE OF INSURABILITY INFORMATION

Attach this form with your enrollment card and submit to Jefferson Pilot Financial Insurance Company (herein referred to as "the Company"). Please complete a form for each applicant. No coverage will be effective until approved in writing by the Company. **Complete all blanks in ink and print clearly.** Incomplete forms will cause coverage to be delayed.

Applicant Information:

Name _____ State of Birth _____ Date of Birth ____/____/____ Male Height _____
Female Weight _____
Relationship to employee _____ Amount Applied For \$ _____ Total Benefit Amount \$ _____

Address _____
(Street) (City) (State) (Zip)

Phone Number Home (____) - ____ - _____ Work (____) - ____ - _____ Best Time to call _____ Home Work

Beneficiary (for Life or AD&D Insurance) _____ Relationship _____

Plan Applied for: Life Optional Employee Life Voluntary Employee Life
Dependent Life Optional Employee AD&D Voluntary Employee AD&D
STD Optional STD Voluntary Spouse Life
LTD Optional LTD Voluntary Spouse AD&D
Critical Illness Optional Spouse Life Voluntary STD
Optional Spouse AD&D Voluntary LTD

Employee Information:

Name _____ Group Name _____
Employee Social Security Number _____ Group Policy Number _____ Group ID _____
Annual Earnings \$ _____ Date of Hire/Rehire ____/____/____

STATEMENT OF HEALTH

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 7 years, have you ever (a) had, or (b) been told by a physician that you had, or (c) received treatment for a condition listed below? CIRCLE CONDITIONS ANSWERED YES AND PROVIDE DETAILS BELOW. | | |
| A. Heart or artery disorder, heart attack, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. High blood pressure? If YES, please note last two readings and date of reading: | <input type="checkbox"/> | <input type="checkbox"/> |
| Date _____ Reading _____ Date _____ Reading _____ | | |
| C. Diabetes? If YES, please note age of onset, and treatment prescribed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Age at onset: _____ Type of treatment: _____ | | |
| D. Cancer, leukemia, malignant growth or any form of tumor?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Epilepsy or any mental/nervous disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Alcoholism, drug, or substance abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 7 years, have you: | | |
| A. tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex) caused by the HIV infection or other sickness or condition derived from such infection?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B. been diagnosed as having Hepatitis, any disorder of the immune system or any sexually transmitted disease, other than AIDS or ARC? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any physical examinations in the last 5 years? If YES, provide details below and note reason for exam, symptoms, treatment or medication and results. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Within the past 5 years, have you had any physical disorder not listed above?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered YES to questions 2-5, please give complete details on back page:

Item No.	Condition, injury, or findings of exam. If surgery performed, state type.	Date of Onset	Date Last Treated	Results/Degree of Recovery	Name & Address of Attending Physician

YES NO

6. Are you:
- A. Under observation or receiving treatment?
- B. Taking medication?

If you answered YES to questions 6A or 6B, please provide details below:

Condition	Date of Onset	Name of Medication	Dosage and Frequency	Name and Address of Attending Physician

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

CONTINUED ON NEXT PAGE

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

MEDICAL INFORMATION BUREAU

We, or our reinsurers, may make a brief report to the Medical Information Bureau, an organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another member company for insurance, or make a claim for benefits, the Bureau may supply information in its file to such a company.

Upon receipt of a request from you, the Bureau will arrange disclosure of information in your file. If you question the accuracy of the information, you may contact the Bureau and seek correction in accordance with the Fair Credit Reporting Act. The address of the Bureau's information office is P. O. Box 105, Essex Station, Boston, MA 02112; phone number -- (617) 426-3660.

We, or our reinsurers, may also release information in our 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.

PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Home Office, you may receive a telephone call from a specially trained Home Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:

Jefferson Pilot Financial Insurance Company
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS