Evidence of Insurability Cover Sheet

Please forward this cover sheet with your completed Evidence of Insurability form to American Family Life Assurance Company of New York using one of the following:

- Mail – Medical Underwriting, P.O. Box 8348, Columbus, GA 31908-8348
- Fax – 1-800-206-4063
- Email – myPLADSadmin@aflac.com

To be completed by benefits representative

Group Name/Policy Number:	Church Pension Fund GLDNY01112
Employee Name:	

	Current Percentage In Force	Total Requested Percentage
Short Term Disability Coverage		
Long Term Disability Coverage		

Aflac

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF NEW YORK

22 Corporate Woods Boulevard • Suite 2 • Albany, New York 12211
(866) 849-2964

("THE COMPANY")

Evidence of Insurability

Group Life and Disability Insurance

Medical Underwriting: P.O. Box 8348 Columbus, GA 31908-8348	Phone: (800) 206-8826 Fax: (800) 206-4063 Email: myPLADSadmin@aflac.com

Instructions

Complete each section of the application. Use blue or black ink

- Each applicant must complete their own application.
- Indicate your answers for each health question by checking "yes" or "no" box.
- Provide details for any "yes" answers in Section III.
- Read the Acknowledgements.
- Sign and date the form.
- Submit the completed application as instructed below.

Reason for Application: ☐ Open Enrollment ☐ Annual Enrollment ☐ New Hire ☐ Rehire/Reinstatement
☐ Life Event/Family Status Change ☐ Late Applicant ☐ Change in Salary Multiple ☐ Change in Increments
☐ Requesting an Amount in Excess of Plan's Guarantee Issue Amount

Section I: Employee Information – print or type all information requested.

_____ _____
Employee Name Employee ID Number

_____ _____ _____ _____
Home Address (Street/P.O. Box) (Apt #) City State Zip Code

_____ _____ _____
Phone Number E-mail Address Social Security Number

Church Pension Fund **GLDNY01112**
Employer Name Group Policy Number

Gender: ☐ Female ☐ Male _____ _____ _____
Age Date of Birth (MM/DD/YYYY) Annual Salary

Do you live outside of the U.S.? ☐ Yes ☐ No
Do you work outside of the U.S.? ☐ Yes ☐ No Work/Residence Country: _____

Dependent Information

Complete if evidence of insurability is required for a dependent of the employee

Relationship to Employee	Name	Age	Date of Birth	Gender	Social Security #	Email Address
N/A	N/A					

Coverage Applied for: complete for each coverage requiring evidence of insurability.

Employee Life Coverage	Basic Life	Supplemental Life	Survivor Income
Current Amount	$ N/A	$ N/A	$ N/A
Additional Amount Requested	$ N/A	$ N/A	$ N/A
Total Amount if Approved	$ N/A	$ N/A	$ N/A

Dependent Life Coverage	
Current Amount	$ N/A
Additional Amount Requested	$ N/A
Total Amount if Approved	$ N/A

Employee Disability Coverage	Short Term Disability	Long Term Disability
Current % of Salary	%	%
Current Coverage Amount	$	$
Additional Requested % of Salary	%	%
Total Coverage Amount if Approved	$	$

Section II – Health Questions

Provide current height and weight

Employee Height _____ ft _____ in Employee Weight _____ lbs
Dependent Height _____ ft _____ in Dependent Weight _____ lbs

Primary Care Provider Information

Employee's Provider's Name: _____ Phone: _____
Address_____ City _____ State _____ Zip _____

Dependent's Provider's Name: _____ Phone: _____
Address_____ City _____ State _____ Zip _____

Answer the following questions by checking "yes" or "no." Provide details to "yes" answers in Section III.

	Part A To the best of your knowledge and belief:	**Employee**	**Dependent**
1.	In the past 12 months, have you used any tobacco products (such as cigarettes, cigars, snuff, dip, chew, or pipe), or any nicotine delivery system?	☐ Yes ☐ No	☐ Yes ☐ No
2.	In the past 12 months, have any inpatient or outpatient, medical, surgical or diagnostic procedures been recommended by a medical professional and are currently under consideration or scheduled for you, except those tests related to the Human Immunodeficiency Virus (Acquired Immune Deficiency Syndrome-AIDS or Human Immunodeficiency Virus-HIV)?	☐ Yes ☐ No	☐ Yes ☐ No
3.	In the past 3 years, have you been an inpatient or outpatient or treated at a hospital, clinic, or other medical facility?	☐ Yes ☐ No	☐ Yes ☐ No
4.	In the past 7 years, have you used narcotics, sedatives, amphetamines, opioids, cocaine, methamphetamines, heroin, hallucinogens, Ecstasy (MDMA), Lysergic Acid Diethylamide (LSD), Phencyclidine (PCP), except as prescribed by a physician?	☐ Yes ☐ No	☐ Yes ☐ No
5.	In the past 7 years, have you have you received medical treatment or counseling for, or been advised by a medical professional or a licensed physician to reduce and/or discontinue the use of alcohol, or prescribed or non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No
6.	In the past 3 years, has your driver's license been suspended or revoked? Have you in the past 5 years, been convicted of driving while impaired, intoxicated, or under the influence of alcohol or any drug?	☐ Yes ☐ No	☐ Yes ☐ No
7.	In the past 7 years, have you been diagnosed or treated by a licensed physician, or licensed member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No

Section II – Health Questions (continued)

Part B: Answer the following questions by checking "yes" or "no." Provide details to "yes" answers in Section III.

	In the past 7 years, to the best of your knowledge or belief, have you been medically diagnosed, treated, hospitalized, or prescribed medication by a licensed physician or a licensed member of the medical profession for:	**Employee**	**Dependent**
8.	Any disease or disorder of the heart or circulatory system including high blood pressure, chest pain, heart attack, coronary artery disease, heart murmur, heart or valve surgery, irregular heart rhythm, stroke/transient ischemic attack (TIA), congestive heart failure or cardiomyopathy?	☐ Yes ☐ No	☐ Yes ☐ No
9.	Cancer, tumor, nodule, skin cancer (excluding basal cell carcinoma), melanoma, Hodgkin's disease or leukemia?	☐ Yes ☐ No	☐ Yes ☐ No
10.	Diabetes/pre-diabetes, blood disorder (except Acquired Immune Deficiency Syndrome-AIDS or Human Immunodeficiency Virus-HIV), or disease of the pituitary or adrenal gland? If yes for diabetes provide your latest A1C reading and the date taken in Section III.	☐ Yes ☐ No	☐ Yes ☐ No
11.	Any disorder or disease of the gastrointestinal system, liver, intestine, stomach, pancreas, rectum including hepatitis, fatty liver, cirrhosis, Crohn's disease or ulcerative colitis?	☐ Yes ☐ No	☐ Yes ☐ No
12.	Any disorder or disease of the genito-urinary system, kidney, bladder or prostate?	☐ Yes ☐ No	☐ Yes ☐ No
13.	Any disorder or disease of the respiratory system including asthma, chronic obstructive pulmonary disease (COPD)/emphysema or sleep apnea?	☐ Yes ☐ No	☐ Yes ☐ No
14.	Any disorder or disease of the brain or nervous system including epilepsy/seizure disorder, paralysis, multiple sclerosis, memory loss, Alzheimer's disease, Parkinson's disease, muscular dystrophy, amyotrophic lateral sclerosis (ALS) or tremor?	☐ Yes ☐ No	☐ Yes ☐ No
15.	Any psychiatric or mental health disorder or disease including anxiety, depression, bipolar disorder, post-traumatic stress, psychosis or eating disorder?	☐ Yes ☐ No	☐ Yes ☐ No
16.	Any disorder or disease of the immune system, systemic lupus, or other auto-immune disorders, except those related to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
17.	Back, neck or joint pain, disc disease, joint replacement, arthritis, muscle disorder, connective tissue disease or fibromyalgia?	☐ Yes ☐ No	☐ Yes ☐ No

Part C – Complete this section if you are applying for Disability Coverage.

To the best of your knowledge and belief:

18.	Within the past 7 years, have you been diagnosed, treated, hospitalized, prescribed medication for or been given medical advice by a licensed physician or licensed medical professional to seek treatment for: colon polyp, thyroid or gall bladder disorder or disease, chronic headaches, chronic fatigue syndrome, gout, carpal tunnel syndrome or any disorder or disease of the eyes, ears or throat?	☐ Yes ☐ No
19.	Within the past 3 years, have you had an application for disability insurance declined, rated, or modified in any way, or filed for, received, or been refused disability benefits?	☐ Yes ☐ No
20.	Within the past 3 years, have you been unable to work or been confined at home for any reason other than colds, flu, or minor injuries?	☐ Yes ☐ No
21.	Are you currently pregnant (female only)?	☐ Yes ☐ No

Section III

1. If you answered "yes" to any of the following questions provide details below to the best of your knowledge and belief.

Q#	Additional Information						
2	Applicant Name	Procedure		Reason			Date Scheduled
3	Applicant Name	Diagnosis	Diagnosis Date	Date of Last Occurrence	Current Status & Symptoms	Treatment, including Surgery, Procedure and Medication	Attending Physician's name, address & phone number
4	Applicant Name	Type of drug used:		Type of treatment, inpatient or outpatient:			Dates of treatment/counseling:
5	Applicant Name	Type of drug or alcohol used:		Type of treatment, inpatient or outpatient:			Dates of treatment/counseling:
6	Applicant Name	Provide dates, state of occurrences, and conviction.					
10	Applicant Name	Last A1C reading:					Date of last A1C:
19	Applicant Name	Provide Details					
20	Applicant Name	Provide Details					

2. To the best of your knowledge and belief, provide details below to "yes" answers provided in Section II Part(s) B & C (other than provided in 1 above).

Applicant Name	Q#	Diagnosis	Diagnosis Date	Date of Last Occurrence	Current Status & Symptoms	Treatment, including Surgery, Procedure and Medication	Attending Physician's name, address & phone number

3. List all medications and prescription drugs that you are currently taking to the best of your knowledge and belief.

Applicant Name	Medication (name, dosage, frequency)	Reason Taking	Date Started

The Company reserves the right to request additional health information based on the responses given by the applicant.

Voluntary Electronic Transactions Opt-in Consent Disclosure

Voluntary Opt-in:
The Company will permit you to sign this application electronically and will deliver a copy of this application to you by electronic means if you voluntarily opt in. If this application is signed and delivered electronically, it will have the same force and effect as if it had been completed and delivered to you in paper format. If you elect to Opt-in, it will also apply to future transactions/documents, if any.

Right to Paper Records:
If you do not consent to sign electronically, you may print this form or request a paper form from the policyholder or our Medical Underwriting Unit. If you consent to signing and receiving delivery of this application electronically, The Company will provide one paper copy of this application to you per year at no charge, upon your request.

Right to Withdraw Your Consent:
You can change your mind at any time and withdraw your consent to all electronic transactions by notifying The Company using one of the methods provided below. If you withdraw your consent, The Company will transmit this application and all other transactions to you in paper format via mail. If you wish to change your email address, you can do so at any time by notifying The Company using one of these methods:

Telephone: 800-206-8826
Email: myPLADSadmin@aflac.com

The Company's website is www.Aflac.com.

Voluntary Consent:
I have read, understand and agree to this *Voluntary Electronic Transactions Opt-in Consent Disclosure.* By checking "I Agree" and providing my electronic signature below, I voluntarily consent to signing, receiving, and transmitting this application and related documents electronically. I understand I can change my mind at any time and remove my consent to electronic transactions.

☐ I Agree

_____
Signature of Proposed Insured

Acknowledgements

By signing the Acknowledgements, I (we) apply for the insurance requested and understand and agree to all the following:

- An electronic copy of this application will be as valid as the original.
- I (We) and/or my (our) authorized representative may receive a copy of this application upon request.
- I (We) may need to provide more medical information, take an exam, or medical tests, and report the results to The Company. Authorization may be required to conduct HIV testing.
- No producer or agent has authority to waive any answer or otherwise modify this application or to bind The Company in any way by making any promise or representation which is not set out in writing in this application.
- No insurance will take effect unless this application is approved by The Company, the first full premium is paid, all answers are set forth in the signed application, and continue to be true and complete to the best of my (our) knowledge and belief on the effective date of coverage.
- The Company will rely on the information provided in this application to evaluate the request for insurance. If the answers provided contain a material misrepresentation, the Company may adjust or deny the requested coverage.
- Any change in the plan or benefits, amount of insurance, or classification of risk will not become effective until The Company has approved them in writing.
- All statements contained in this application for insurance are deemed representations and not warranties.
- **Applicable to Life Insurance only:** The policy permits the group policyholder (employer) to change, reduce, restrict or terminate my rights or benefits under the policy without my consent and such change, reduction, restriction or termination may occur at a time when my health status has changed and may affect my ability to procure individual coverage.
- PRE-EXISTING CONDITIONS LIMITATION: Applicable to Disability Income Insurance only. *I understand and agree that the coverage that I am applying for may have a pre-existing condition limitation period. (Check your certificate for the definition of pre-existing condition.)*

Signature

I (We) authorize The Company, or its reinsurers, to release the obtained information in its file(s), including personal health information, to its reinsurers, or other insurance companies, MIB, LLC, or insurance support organizations performing business or legal services in connection with my application, a claim or as required by law. I (We) authorize The Company, or its reinsurers, to make a brief report of my personal health information to MIB, LLC.

To assess eligibility for this group insurance, The Company requires that I (we), the undersigned proposed insured, authorize disclosure of my medical and non-medical personal information. Information received will be used to: (a) underwrite insurance; (b) verify the accuracy of the information given in this application; and (c) determine my eligibility and/or The Company's obligations under the group policy. I (We) will be required to sign an authorization to release this information.

I (We) have read or have had read to me (us) this application. I (We) agree that all statements and answers I (we) have given, including any health information, are true and complete to the best of my knowledge and belief. I (We) acknowledge that this application, and any additional questionnaires and medical examination forms, completed and signed by me (us), are part of this application and will be used by The Company to determine whether I am (we are) eligible for coverage. By signing below, I (we) acknowledge that I (we) understand and agree to the terms of this application for insurance.

☐ I Agree

☐ I Disagree

I intend to sign this EOI application electronically. To print a copy of the application, follow the instructions on the website. If you need a paper copy because you did not print, contact us at (800) 206-8826 or by email at myPLADSadmin@aflac.com.

Revocation and Refusal to Sign: You will need to sign a separate authorization. This authorization may be revoked at any time by writing to our Administrative Office. A revocation will not: (1) change any action taken in reliance on the Authorization; or (2) change our right to use the authorization for contest of a claim, benefit, or my (our) coverage under the policy. Revocation may be the basis for denying coverage, an increase in coverage, or benefits. Refusal to sign this authorization may affect your ability to obtain, increase, or reinstate insurance coverage offered in this application, and may be the basis for denying the application.

I UNDERSTAND THAT CERTAIN WAR OR TRAVEL RISKS ARE NOT ASSUMED. IN CASE OF ANY DOUBT, WRITE TO US FOR FURTHER EXPLANATION.

Receipt of accelerated benefits may affect eligibility for public assistance programs and may be taxable.

Fraud Notice: This notice is only applicable to Disability Income insurance coverage. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The above statements and answers are true and complete to the best of my (our) knowledge and belief.

_____
Signature of Proposed Insured

_____
Signature of Additional Proposed Insured

Signed in _____ on _____
City and State Month/Day/Year

Please retain a copy of this fully completed application for your records. You may submit this form electronically, or by mail or fax it to:

Medical Underwriting
P.O. Box 8348 • Columbus, GA 31908-8348 • Toll Free (800) 206-8826 • Fax (800) 206-4063

MIB, LLC Pre-Notice

Information regarding your insurability will be treated as confidential: The Company or its reinsurer(s) may however, make a brief report thereon to MIB, LLC, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life, health insurance or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request for you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866)692-6901 TTY (866)346-3642. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to who a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Authorization to Obtain and Release Health Related Information

To: American Family Life Assurance Company of New York
P.O. Box 84075
Columbus, GA 31993

This authorization is for determining my eligibility for insurance, including checking for and resolving any issues that may happen because of incomplete or incorrect information given on my Evidence of Insurability Application.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription drug history, and any other health or billing information and any other protected health information concerning me to American Family Life Assurance Company of New York ("the Company") and its agents, employees, representatives, reinsurers, and those persons or entities providing services to the Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of tobacco, but does not include substance use disorder records or psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility or other health care provider to release and disclose my entire medical record without restriction, other than substance use disorder records or psychotherapy notes.

This authorization will remain in force for two years following the date of my signature below. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a letter to:

Medical Underwriting
P.O. Box 8348 • Columbus, GA 31908-8348
Fax (800) 206-4063

I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and may no longer be covered by federal rules governing privacy and confidentiality of health information once it is disclosed.

I understand that My Providers may not refuse to provide treatment, payment for health care services, or enrollment or eligibility for benefits if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application.

_____	_____
Name of Proposed Insured (please print)	Date of Birth
_____	_____
Employee Signature or Personal Representative	Date
_____	_____
Spouse Signature or Personal Representative	Date

_____
Description of Personal Representative's Authority or Relationship to Proposed Insured

**Administrative services are offered by Continental American Insurance Company (CAIC) in all states but NY. In NY, administrative services are offered by American Family Life Assurance Company of NY. In CA, CAIC does business as Continental American Life Insurance Company.*