Evidence of Insurability Cover Sheet

Please forward this cover sheet with your completed Evidence of Insurability application to Zurich American Life Insurance Company at one of the following:

- Mail - Zurich Medical Underwriting, PO Box 1685, Grand Rapids, MI 49501-1685
- Fax – (800) 206-4063
- Email - myzurichadmin@zurichna.com

To be completed by a benefits representative

Group Name/Policy Number:	Church Pension Fund, CNYEX01112
Employee Name:	
Employee Annual Salary:	

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

Evidence of Insurability for Group Insurance

ZURICH

Zurich American Life Insurance Company

Administrative Office
Zurich Medical Underwriting
PO Box 1685 Grand Rapids MI 49501

Phone: 1-800-206-8826
Fax: 1-800-206-4063
Email: myzurichadmin@zurichna.com

Plan requested: ☐ Basic Life ☐ Supplemental Life ☐ Survivor Income ☐ Long Term Disability ☐ Short Term Disability

Instructions

Complete each section of the application. Forms with missing information will be returned. Use blue or black ink.

- **Indicate your answers for each health question by checking "Yes" or "No" box.**
- **Provide details for any "Yes" answers in Section III.**
- **Read the Authorizations and Acknowledgements.**
- **Sign and date the form.**
- **Deliver the completed form to the Administrative Office by mail, fax or as provided below in the instructions for secure electronic submission.**

Application Type: ☐ Not Specified ☐ Open Enrollment ☐ Annual Enrollment ☐ New Hire ☐ Rehire/Reinstatement
☐ Life Event / Family Status Change ☐ Late Applicant ☐ Change in Multiple ☐ Change in Increments
☐ Requesting an Amount in Excess of Plan's Guarantee Issue Amount

Section I: Employee Information - please print or type all information requested

Employee Name (First, Middle, Last) _____ Employee ID Number _____

Home Address (Street/PO Box) Apt # _____ City _____ State _____ Zip Code _____

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

Church Pension Fund
Employer Name _____ Work Location / Division _____ Group Policy Number CNYEX01112

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

Marital Status: _____ Employee Class _____

Do you live outside the U.S.? ☐ Yes ☐ No Do you have a Visa or Green Card? ☐ Yes ☐ No ☐ Green Card

Visa country: _____ Country of Citizenship: _____

Do you work outside the U.S.? ☐ Yes ☐ No Work Country: United States

Dependent Applicant Information - complete if evidence of insurability is required for a dependent of the employee

Relationship to Employee	Name	Age	Date of Birth mm/dd/yyyy	Gender	Social Security Number	Occupation	Email Address

Coverage Applied for: (complete for each coverage requiring evidence of insurability)

Employee Life Coverage	Basic Life	Supplemental Life
Current Amount	$	$
Additional Amount Requested	$	$
Total Amount if Approved	$	$

Coverage Applied for: (complete for each coverage requiring evidence of insurability) *(Continued)*

Dependent Life Coverage	Spouse/Partner	Child 1	Child 2
Current Amount	$	$ N/A	$ N/A
Additional Amount Requested	$	$ N/A	$ N/A
Total Amount if Approved	$	$ N/A	$ 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		

Is the disability insurance applied for in this application intended to replace any other accident and health insurance presently in force with the policyholder? Yes or No

Section II - Health Questions

Provide current height and weight.

Employee Height _____ ft. _____ in. **Weight** _____ lbs.

Dependent Height _____ ft. _____ in. **Weight** _____ lbs.

Answer the following questions by checking "Yes" or "No". Provide detail to "Yes" answers in Section III.

Part A.		EE	Dependent
1.	Within 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.	Within 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, Human Immunodeficiency Virus-HIV, AIDS Related Complex-ARC)? If yes, provide additional detail in Section III, Part D.	☐ Yes ☐ No	☐ Yes ☐ No
3.	In the past 5 years, have you been an inpatient or outpatient, or treated, at a hospital, clinic, or other medical facility, or any similar entity?	☐ Yes ☐ No	☐ Yes ☐ No
4.	In the past 5 years, have you been examined, monitored, or received medical treatment from a member of the medical profession, for any condition other than minor illnesses? [For Maine residents, except Human Immunodeficiency Virus-HIV]	☐ Yes ☐ No	☐ Yes ☐ No
5.	In the past 10 years, have you used narcotics, sedatives, amphetamines, barbiturates, morphine, cocaine/ crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, Lysergic Acid Diethylamide-LSD, Phencyclidine-PCP, opiates, hallucinogens, except as prescribed by a physician?	☐ Yes ☐ No	☐ Yes ☐ No
6.	In the past 10 years, have you received medical treatment or counseling for, or been advised by a medical professional to reduce, discontinue the use of alcohol, or prescribed or non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No
7.	**For CT Residents: To the best of your knowledge and belief have you ever had, been told you had, or have you ever been treated for, Acquired Immune Deficiency Syndrome-AIDS, AIDS Related Complex-ARC or Acquired Immune Deficiency Syndrome-AIDS related conditions?**	☐ Yes ☐ No	☐ Yes ☐ No

*EE = Employee

Section II - Health Questions *(continued)*

Part B: In the past 10 years (residents of IN, KS, and OR, 5 years, and residents of MD 7 years), have you been diagnosed, treated, hospitalized, tested positive for, prescribed medication for, or given medical advice, by a member of the medical professional for any of the following diseases or disorders such as:

	Provide detail to "Yes" answers in Section III.	EE	Dependent
8.	Any disease or disorder of the heart, blood vessels, or circulatory system such as high blood pressure, stroke, heart attack, chest pain, heart or valve surgery, coronary artery disease, Transient Ischemic Attack (TIA), high cholesterol, Atrial Fibrillation, Angina, heart murmur, Congestive Heart Failure, Cardiomyopathy,or irregular heart rhythm? If yes, provide your last blood pressure reading and the date taken in Section III.	☐ Yes ☐ No	☐ Yes ☐ No
9.	Any cancer, tumor, mass, skin cancer, cyst, nodule, including melanoma, leukemia, lymphoma, colon polyp, or any malignant or benign growth?	☐ Yes ☐ No	☐ Yes ☐ No
10.	Diabetes, impaired glucose tolerance (pre-diabetes), anemia, or blood disorder (except Acquired Immune Deficiency Syndrome-AIDS, Human Immunodeficiency Virus-HIV, AIDS Related Complex-ARC), or a disease or disorder of the skin, thyroid, pituitary, adrenal, lymph, or other glands? 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 liver, pancreas, digestive system, stomach, rectum, abdominal organs, intestines, or spleen, including hepatitis, ulcers, fatty liver, Irritable Bowel Syndrome (IBS), cirrhosis, Crohn's disease or Ulcerative Colitis, gastrointestinal disorder (digestive or intestinal), or gall bladder disorder?	☐ Yes ☐ No	☐ Yes ☐ No
12.	Any disorder or disease of the genito-urinary organs, or kidney, bladder, urinary, reproductive organ, or prostate disorder or sexually transmitted disorders or diseases (except Acquired Immune Deficiency Syndrome-AIDS, Human Immunodeficiency Virus -HIV, AIDS Related Complex-ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
13.	Any disorder or disease of the respiratory system including Asthma, Chronic Obstructive Pulmonary Disease (COPD), Emphysema or chronic bronchitis, sleep apnea or any other disease or disorder of the lungs or respiratory system?	☐ Yes ☐ No	☐ Yes ☐ No
14.	Arthritis, Systemic Lupus, gout, back, knee, joint pain, bone fracture, muscle disorder or other connective tissue disease, Chronic Fatigue Syndrome, disc disease, Fibromyalgia, Temporomandibular Joint (TMJ) Disease or joint replacements?	☐ Yes ☐ No	☐ Yes ☐ No
15.	A disorder or disease of the brain or nervous system including: Epilepsy, or chronic headaches, paralysis, multiple sclerosis, memory loss, Alzheimer's disease, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease), Huntington's disease, Parkinson's disease, seizure, convulsion, fainting, loss of consciousness, tremor?	☐ Yes ☐ No	☐ Yes ☐ No
16.	Any psychiatric or mental health disorder or disease including but not limited to: anxiety, eating disorder (anorexia or bulimia), depression, Schizophrenia, psychosis, bipolar disorder, post-traumatic stress, or traumatic stress disorder?	☐ Yes ☐ No	☐ Yes ☐ No
17.	Any disorders or diseases of the immune system, except those related to the Human Immunodeficiency Virus(HIV), Acquired Immune Deficiency Syndrome(AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
18.	Any disorder of disease of the eyes, ears, nose, throat, or tonsils?	☐ Yes ☐ No	☐ Yes ☐ No

*EE = Employee

Section III

Part A

Please provide the following information, if you answered "Yes" to any of the following questions.

Q#	Applicant Name	Additional Information		
5/6		Provide type of drug or alcohol used, provide types and dates of treatment or counseling.		
8		Provide your last blood pressure reading and the date taken:	Blood Pressure:	Date:
10		Provide your last A1C: reading and the date taken:	A1C:	Date:

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Part B

Provide details to "Yes" answers (other than provided in Part A) below: (provide a separate page if necessary).

Applicant Name	Q. #	Diagnosis/ Condition	Date of Occurrence	Current Status (including details and symptoms)	Medications (including dosages and frequency)	Exam Results and Treatments received	Date of Recovery (indicate if ongoing symptoms)	Attending Physician's name, address and phone number

Part C

List all medications and prescription drugs you are currently taking.

Applicant Name	Name of Medication	Reason Taking	Date Started

Part D

List any inpatient or outpatient medical, surgical, or diagnostic procedures that have been recommended by a medical professional in the last 12 months and currently under consideration or currently scheduled for you, except tests related to the Human Immunodeficiency Virus-HIV, Acquired Immune Deficiency Syndrome-AIDS, or AIDS Related Complex (ARC)?

Applicant Name	Procedure / Treatment	Reason	Date Scheduled

Zurich reserves the right to request additional health information on the basis of the responses given by the applicants.

Authorization To Obtain And Disclose Information

To assess eligibility for this group insurance, Zurich American Life Insurance Company ("Zurich") 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 for insurance; and (c) determine my eligibility and/or Zurich's obligations under the policy.

Authorization:

I (We) authorize any medical practitioner, physician facility, hospital, laboratory, clinic, any insurance or reinsurance company, insurance support organization, Veterans Administration, MIB Inc., employer, policyholder, benefit plan administrator, pharmacy, or pharmacy related service organization; or government agency, to give Zurich American Life Insurance Company, its affiliates, reinsurers, authorized agents, or any third party acting on Zurich's behalf in this regard, all personal information, data, and the records pertaining to me (us), that pertain to: occupational information related to my (our) employment and income, medical information which relates to my (our) past and present, physical, mental, or behavioral health condition, medical history or medical treatment including: disabilities, disorders, injuries, consultations, treatments, diagnoses, drugs prescribed, medical test results, surgeries, confinements in any facility, sexually transmitted diseases; tobacco/nicotine use and treatments, alcohol and drug abuse and treatment, including information and data records related to alcohol, and drug abuse protected by Federal Regulations 42 CFR part 2; Acquired Immune Deficiency Syndrome (AIDS) or Acquired Immune Deficiency Syndrome-AIDS related conditions not including information related to Acquired Immune Deficiency Syndrome-AIDS/AIDS Related Complex-ARC counseling, including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and non-medical information such as motor vehicle records and reports. Any agreements I (We) have made to restrict disclosure of my (our) health information do not apply to this Authorization. Additional authorization will be required to conduct Human Immunodeficiency Virus-HIV testing.

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

For residents of CT and Vermont: This authorization excludes the release of any information relating to any previous test for Human Immunodeficiency Virus-HIV Antibodies, T-Cell Counts, Acquired Immune Deficiency Syndrome-AIDS or AIDS Related Complex-ARC by any person, or entity that may possess such information.

For residents of ME: This authorization excludes disclosure of the result of a test for Human Immunodeficiency Virus-HIV if the applicant has not developed symptoms of the disease Acquired Immune Deficiency Syndrome-AIDS or AIDS Related Complex-ARC. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has Acquired Immune Deficiency Syndrome-AIDS/AIDS Related Complex-ARC.

For residents of VT: I (We) do NOT authorize Zurich to forward the results from any new test requested by Zurich to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

WI Residents: Disclosure of blood test to detect the Human Immunodeficiency Virus-HIV antibody is limited to FDA approved tests. Information regarding any test performed at an alternate test site designated by the state epidemiologist, or an anonymous home test kit, need not be provided.

Acknowledgements

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

- Information relating to Human Immunodeficiency Virus-HIV test results will only be disclosed as permitted by applicable state law.
- A photographic copy of this authorization will be as valid as the original.
- I (we) and/or my authorized representative, may receive a copy of this authorization upon request.
- Any change to my health that happens before the insurance is effective must be reported to Zurich American Life Insurance Company.
- I (we) may need to provide more medical information, take an exam, or medical tests, and report the results to Zurich American Life Insurance Company. Additional authorizations may be required to conduct Human Immunodeficiency Virus-HIV testing.
- No producer or agent has authority to waive any answer, or otherwise modify this application, or to bind Zurich American Life Insurance 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 Zurich American Life Insurance Company, the first full premium is paid, all answers set forth in the application, together with any amendments and supplements are signed and continue to be true and complete to the best of my knowledge and belief on the effective date of coverage .
- That insurance will not go into effect unless I am actively-at-work on the effective date.
- Zurich American Life Insurance Company ("Zurich") will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, subject to the incontestability provision, Zurich American Life Insurance Company may adjust or deny benefits, or void the insurance requested herein.
- Any change in the plan or benefits, amount of insurance, or classification of risk, will not become effective until Zurich American Life Insurance Company has approved them in writing.
- If I become insured, a pre-existing condition waiting period applies to this plan as defined in the certificate. The waiting period will be reduced by any eligible period of creditable coverage under my prior plan. (Applies to disability insurance only)

Expiration, Revocation and Refusal to Sign: This Authorization is valid for as long as the individual is continually insured with Zurich. This Authorization may be revoked at renewal in writing to Zurich's Administrative Office. A revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change Zurich's right to use the Authorization for contest of a claim, benefit, or my coverage under the policy. Revocation may be the basis for denying coverage, an increase in coverage, or benefits. Refusal to sign this authorization will affect your ability to obtain, increase, or reinstate insurance coverage offered in this application, and may be the basis for denying the application or a claim for benefits.

For residents of ME: This authorization excludes disclosure of the result of a test for Human Immunodeficiency Virus-HIV if the applicant has not developed symptoms of the disease Acquired Immune Deficiency Syndrome-AIDS or AIDS Related Complex-ARC. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has Acquired Immune Deficiency Syndrome-AIDS/AIDS Related Complex-ARC.

For residents of Oregon: If my application for coverage is denied, I am entitled upon request to receive a written response describing the specific reasons for denial, and the specific items of personal and privileged information that support these reasons.

For residents of Virginia: The authorization will be valid for the term of coverage of the policy for an accident and sickness insurance benefit; and the duration of the claim if not for an accident and sickness insurance benefit.

WI Residents: Disclosure of blood test to detect the Human Immunodeficiency Virus-HIV antibody is limited to FDA approved tests. Information regarding any test performed at an alternate test site designated by the state epidemiologist, or an anonymous home test kit, need not be provided.

Electronic Signature

I agree to the usage of electronic signature and electronic records for current and future transactions pertaining to my application conducted through this website, effective on the date I click the **"Submit"** button. I understand that I have the option to print and retain paper copies of any electronic records generated, and to obtain paper copies of any electronic records generated during website transactions concerning my coverage(s) by contacting Zurich American Life Insurance Company ("Zurich") at 1-800-206-8826 or **email** myzurichadmin@zurichna.com.

I understand this consent is voluntary and that to obtain paper copies of electronic records kept by Zurich, concerning my coverage(s), or to withdraw my consent to usage of electronic records, I must contact Zurich. I understand that in the event my personal contact information changes, or my email address changes, or any error is detected, I must immediately notify Zurich. I understand that to assess and conduct transactions relating to my coverage, I must have access to a personal computer at my home or workplace which is capable of supporting Internet access, and a compatible browser application.

I understand that portions of, or all of the data collected to create this application, including my signature, may be transmitted by electronic means and/or retained in electronic format. By signing below, I consent to this transaction by electronic means and confirm that I have not withdrawn my consent. I may receive a copy of this application upon written requested directed to Zurich American Life Insurance Company.

I have read, or have had read to me, this completed Evidence of Insurability ("application"). I agree that all statements and answers I have given, including any health information, are true and complete to the best of my knowledge and belief. I acknowledge that this application, and any additional applications, application amendments, application supplements, questionnaires and medical examination forms, completed and signed by me, are part of the application will be used by Zurich to determine my insurability. By signing below, I acknowledge that I understand and agree to the terms of this application for insurance.

☐ I Agree

☐ I Disagree

I acknowledge receipt of the following notices:

For residents of all states except California, the applicable fraud warning for my state of residence, as shown below.
The long and short term disability certificates provide limited benefits. Review your certificate carefully.
Notice of Information Practices
MIB Pre-Notice

Employee/ Spouse Signature _____ Date _____

State Fraud Notices

Alabama, Arkansas, District of Columbia, New Mexico, Louisiana, Oregon, Rhode Island, West Virginia and all other states except as listed below: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

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

Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance 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.

Maine, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio and Texas: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Virginia: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Zurich American Life Insurance Company or its reinsurer(s) may however, make a brief report thereon to MIB, Inc., 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 from you, MIB will arrange disclosure of any information and 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.

Zurich 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 for Release of Health-Related Information

ZURICH

Zurich American Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

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 Zurich American Life Insurance Company ("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 alcohol, drugs and tobacco, but excludes 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.

This protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and 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 written request for revocation to Zurich American Life Insurance Company's administrative office at Zurich Medical Underwriting, PO Box 1685, Grand Rapids MI 49501, Attention: Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has 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 is no longer covered by federal rules governing privacy and confidentiality of health information.

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, or if coverage has been issued, may not be able to make any benefit payments. I understand that I am entitled to receive a signed copy of this authorization.

Case Number:

_____
Doctor/Physician or Facility Name

_____ _____
Name of Proposed Insured (please print) Date of Birth

_____ _____
Employee/ Spouse Signature or Personal Representative Date

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

Original to Zurich American Life Insurance Company • Copy to Proposed Insured

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Notice of Insurance Information Practices

ZURICH

Zurich American Life Insurance Company
Zurich American Life Insurance Company of New York

Administrative Office Phone: 1-800-206-8826
Zurich Medical Underwriting
PO Box 1685 Grand Rapids MI 49501

To issue and underwrite insurance we need information about you and other persons that apply for insurance. Some of that information will come from you and some may come from other sources. That information along with any additional information we (or an agent) collect, may, in certain circumstances be disclosed to third parties without your authorization, as permitted by law.

You have the right to review and correct the information collected about you.

If you wish to have a more detailed explanation of our information practices or how to access your personal file, please call us at our **Customer Service Number:** 1-800-206-8826. We will provide you with a further description of the circumstances under which information about you may be disclosed, the types of persons and organizations to whom it may be disclosed, and the procedure to access, correct, amend and delete information from your personal file.

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Zurich American Life Insurance Company, Zurich American Life Insurance Company of New York, or its reinsurer(s) may however, make a brief report thereon to MIB, Inc, 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 from you, MIB will arrange disclosure of any information it may have 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 address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Zurich American Life Insurance Company, Zurich American Life Insurance Company of New York, 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.

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