New Hampshire Insurability Information Request



Please keep a copy of this form/notice for your records

Group no.	

Return completed form to: NHAD Services, Inc. - Insurance Division PO Box 2337 Concord, NH 03302-2337 Anthem Life Insurance Company PO Box 182361 Columbus, OH 43218-2361 Phone 1-800-551-7265 Fax 1-614-433-8880

Evidence required because of: Over guaranteed issue amount Late er SECTION 1: GENERAL INFORMATION Last name Social Security no.	ntrant \square		e of benefits	This evidence is pr	ovided for:							
SECTION 1: GENERAL INFORMATION Last name	ntrant L		e of benefits	An offective d			This evidence is provided for:					
Last name		г:.		All effective us	ate under a n	ew group	∟ A po	ost group effec	tive date	addition		
Social Security no.		FI	rst name			M.I.	Date	e of birth (MM/D	ID/YYYY)			
Social Security no.	Maulinhan					Empil on	Iduasa					
	Work phone no.		Home phone r	one no.		Email address						
Employee address		City			State ZIP code			State of birth	Height	Weight		
Employee dudiess		oity			Otato	211 0000	,	otate of birtin	11018111	Wolght		
Name of employer				Employer addre	ess			l				
SECTION 2: DEPENDENT INFORMATION — Co	mplete fo	r all de	pendents (if a	ny) to be covered	d under this	program.						
Last name, first name, M.I. S		Date of birth (MM/DD/YYYY)		State of birth	Social Security no.		Relationship		Height	Weight		
							Spouse					
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SECTION 3: MEDICAL AND ACTIVITIES QUEST	TIONNAIRE											
COMPLETE THE FOLLOWING MEDICAL QUESTIONS F includes but is not limited to: a doctor, nurse, psy Christian Science practitioner, or any person affil 1. Are you or any of your dependents currently pr If "Yes," who: Expected due date: (MM/DD/YYYY)	rchologist, iated with	psychia ¹	trist, social wor	ker, chiropractor, p h as Alcoholics Ano o 4. Have you or by, or receiv	odiatrist, ther nymous, a sub any of your do ed treatment	rapist, patho ostance abus ependents e from, a men	logist, c se progr ver bee nber of	lentist, optome ram, or a weight n diagnosed	trist, osteop loss progra	oath,		
					ted Complex (,		es 🗆 No		
	/ou or any of your dependents smoked or used tobacco been plast five years? Show Yes No 6. In the inpati				i. In the past three years have you or any of your dependents been prescribed medication?				es 🗆 No			
in the last five years? If "Yes," who:				6. In the past 10 years have you or any of your dependents had an inpatient admission and/or outpatient surgery?								
Quit date (if applicable): (MM/DD/YYYY) 3. In the past 10 years, have you or any of your displayed to the past 10 years.				social practit	ast 3 years, h cal treatment tioner to seek the answers t	, or been adv treatment f	vised by or any o	a medical or condition not	□Y	es 🗆 No		
treated or diagnosed by a member of the medi a. High blood pressure or high cholesterol? If "Yes," who: Last three readings:	cal profess 	sion for:	□Yes □N	for, or refusi	any of your do ed reinstatem f yes, name o	ent or renew	ıal of, li			es 🗆 No		
b. Heart disease, cancer, diabetes, arthritis, or c. Counseling by a medical or social practitions			☐ Yes ☐ N	9. In the past 3				ependents beer				
emotional, mental or nervous condition? d. Alcoholism, substance abuse or chemical de		or	☐ Yes ☐ N	engaged in s	ports or hobb	ies such as a		2 months being , scuba diving,	· —	oo 🗆 Ne		
been convicted for driving while intoxicated? $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$		diving, racing, or similar activities?				es 🗆 No						

SECTION 3: MEDICAL AND ACTIVITIES QUESTIONNAIRE (continued)							
Explain any "Yes" answers below. If additional space is necessary, attach a separate page including your signature and date.							
Question no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital	

SECTION 4: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this 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, Massachusetts 02184-8734; and telephone number is 1-866-692-6901. (TTY: 1-866-346-3642 for hearing impaired).

SECTION 5: AGREEMENT AND AUTHORIZATION

- 1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB Group, Inc., to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a mor
- 2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
- 3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
- 4. I understand that Anthem Life Insurance Company reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this information request may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this information request form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

Applicant signature	Date (MM/DD/YYYY)
X	
Spouse signature (If to be covered)	Date (MM/DD/YYYY)
X	
This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: Anthem, PO Box 18 must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may REFUSAL OF AUTHORIZATION — I refuse authorization to disclose health care information. I understand that such refusal	result in denial of coverage or denial of a claim.
Applicant signature X	Date (MM/DD/YYYY)
Spouse signature (If to be covered)	Date (MM/DD/YYYY)

Fraud Warning: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.