# Evidence of Insurability Statement
# Life Insurance Coverage
**Aetna Life Insurance Company**

**United Nations**

**Read This Instruction Page Carefully.**

**Guidelines for Applicant**

You are required to provide an Evidence of Insurability Statement if one of the following applies:

- You did not request coverage within the initial eligibility period for your employer's group plan of benefits;
- You are requesting an increase in life insurance coverage by revocation of a waiver in place prior to 1 January 2001.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

**Instructions**

**Plan Sponsor/ Employer**

On "Page 3 of 4," verify that all items are completed. ***Be sure that*:**

- The staff member's payroll index number is provided in A2.
- The staff member's address and office E-mail are shown in A4 and A6.
- A7 is signed by your Authorized Representative.

Aetna will advise you of its coverage decision. Staff member will be notified directly if coverage is denied.

**Staff Member**

**Read the Privacy Notice and Misrepresentation sections on "Page 2 of 4" of this Statement before completing it.**

On "Page 3 of 4," provide your **payroll index number, address and office E-mail** in Section A2, A4 and A6. We may need to direct additional inquiries to your attention.

Complete Section B. ***Be sure that*:**

- All items are completed.
- **Height and weight** are provided in B1, or this form will be returned unprocessed for your completion.
- Accurate dates and full details are given in B3 for all "**Yes**" answers in the Statement of Health (B2).

On "Page 4 of 4," read the **Certification**, **Acknowledgment** and **Authorization**, then **sign** and **date** this form.

Make a copy for your records. Return the **original** to:

**Health and Life Insurance Section**

**UNITED NATIONS**
**New York, NY 10017**

for forwarding to Aetna Life Insurance Company.

If a final underwriting decision cannot be made within **six months**, Aetna reserves the right to request a new Evidence of Insurability Statement.

**Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.**

**Make a copy for your records.**

## Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

**Disclosure of Information to Others**

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

**Your Right of Access and Correction**

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Medical Underwriting Department
66 Sigourney Street
Hartford, CT 06160-5000

## Misrepresentation

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.

# Evidence of Insurability Statement
# Life Insurance Coverage

**Aetna Life Insurance Company**

**United Nations**

## A. Plan Sponsor/Employer Information/Certification — Staff Member: Complete this Section - Please print.

| 1. Control Number | Suffix | Account | 2. Payroll index number |
|---|---|---|---|
| 14008 | 10 | 002 | |

3. Plan Sponsor/Employer Name & Address

**United Nations**

ATTN: **Health and Life Insurance Section**

**First Avenue at 42nd Street**
Street

**New York** **NY** **10017**
City State ZIP Code

4. **Name and address**

5. Plan Sponsor - Authorized Rep. Telephone Number
**(212) 963- 5806**

6. **Office E-mail**

**7. I certify the above information is provided in accordance with procedures established for this group plan.**

Plan Sponsor/Employer - Authorized Representative's Signature | Plan Sponsor/Employer - Authorized Representative's Name (Please print) | Date Signed

## B. Staff Member: Complete this Section - Please print.

**1. Personal Information** (cm : 2.5):12 kilos x 2.2

| Name | Birth date *(MM/DD/YYYY)* | Birth place | Sex | Height (ft., in.) | Weight (lbs.) |
|---|---|---|---|---|---|
| | | | | | |

**2. Statement of Health by above Staff Member.** Give complete dates and details for "**Yes**" answers using the space provided in Number 3.

| | Yes | No | |
|---|---|---|---|
| a. | ☐ | ☐ | Are you currently scheduled or recommended for an inpatient or outpatient surgical/diagnostic procedure? If "**Yes**", list type of procedure. |
| b. | ☐ | ☐ | Are you currently taking medication(s) for any condition? If "**Yes**", list diagnosis, medication, dosage and indicate duration of use. |
| c. | ☐ | ☐ | Do you use tobacco products (includes cigarettes, cigar, pipe and chewing tobacco)? |

**Within the past 10 years have you consulted a physician, received medical treatment for or been diagnosed with any of the following illnesses or conditions?** ***(If "Yes" is checked below, circle all conditions that apply.)***

| | Yes | No | |
|---|---|---|---|
| d | | | |
| e. | ☐ | ☐ | Chest pain, high blood pressure, stroke, disease of the heart, circulatory system or blood disorder? |
| f. | ☐ | ☐ | Cancer, tumor, lupus, rheumatoid arthritis, AIDS, HIV-related disorders * or any other immune system deficiency disorder? |
| g. | ☐ | ☐ | Respiratory: bronchitis, asthma, emphysema, any other lung disorder/disease? |
| h. | ☐ | ☐ | Diabetes, kidney disease, disorder of the pancreas, liver, intestines or stomach? |
| | ☐ | ☐ | Nervous system: epilepsy, paralysis, progressive/chronic neuromuscular diseases, substance abuse (alcohol/drugs) or mental illness? |

* AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

**3. Use this space to provide the details for "Yes" answers in Number 2 above.**

| Ques.No | Diagnosis | Date of Onset (day/month/year) | Details/Symptoms | Treatment(s) Received | Full Recovery Date (day/month/year) |
|---|---|---|---|---|---|
| | | | | | |

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☐ ***Check here if you are providing additional information on a separate attachment.***

**Certification:** I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for group coverage and I acknowledge that I have been given a copy of this document as completed by me.

**Acknowledgment:** I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, fraud provisions and staff member actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

**Authorization:** To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed (Minnesota residents twelve [12] months)**. I acknowledge that I have read the Privacy Notice and Misrepresentation sections on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

| Staff member's signature (***required***) | Date (**required**) (day/month/year) |
|---|---|
| | |