CHURCH LIFE INSURANCE CORPORATION

445 Fifth Avenue
New York, NY 10016
(866) 802-6333
www.cpg.org

Health Statement for Group Life

A Health Statement, providing evidence of insurability, is required when the person to be insured applies for late enrollment. Provide all of the information requested and return the Health Statement with your Enrollment Form.

1. Information About the Employee

Date Hired _____/_____/_____ (Mo Day Yr) Soc. Sec. No. _____-_____-_____

_____
Title (The Rev., Mr., Ms., etc.) First Name M.I. Last Name

Home Address

_____
Street

_____
City State Zip

_____
Home Phone Email

Mailing Address (if different)

_____
Street

_____
City State Zip

2. Billing Information

_____
Name of Episcopal Organization

_____
Phone Email List Bill ID

_____
Street

_____
City State Zip

3. Information About Those Applying for Insurance. *Effective date of coverage to be completed by Underwriter.*

☐ Employee

Birth Date _____/_____/_____ (Mo Day Yr) Weight: _____lbs. Height ____ft. ____in.

Coverage Effective _____/_____/_____ (Mo Day Yr)

☐ Dependents

	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Weight (lbs.)	Height (ft./in.)
(a)			____-____-_____	_____/_____/____		
(b)			____-____-_____	_____/_____/____		
(c)			____-____-_____	_____/_____/____		

Coverage effective date: Dependent (a) ____/____/____ (Mo Day Yr) Dependent (b) ____/____/____ (Mo Day Yr) Dependent (c) ____/____/____ (Mo Day Yr)

4. Health Information

If the answer to any of the questions in this section is YES, provide the names of the individuals involved, dates, and other details. Attach a separate sheet if you need more space.

Have any of those applying for insurance (including dependents):		**Details on Questions Answered YES**
1. Ever had, been diagnosed, or treated for a heart disorder, stroke, high blood pressure, tumors, diabetes, any mental or nervous disorder, kidney or liver disease, or respiratory disorder?	☐ Yes ☐ No	_____
2. Been hospitalized or received surgery or medical treatment for any condition in the last 5 years?	☐ Yes ☐ No	_____
3. Ever been treated or diagnosed by a medical professional for:		
AIDS (Acquire Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder?	☐ Yes ☐ No	_____
Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions, or unexplained infections?	☐ Yes ☐ No	_____

5. Signatures - Employee, Dependent

IT IS REPRESENTED that all statements and answers to the above questions are complete and true to the best of my knowledge and belief and IT IS AGREED that all such statements and answers constitute the application, are binding on the Proposed Insured, and adopted by and are binding on this Health Statement Form and shall form the basis for and be part of any such proposed insurance provided by Church Life Insurance Corporation. You also agree that this form, together with the Group Life Enrollment Form you have completed constitutes your application for insurance under the group policy.

_____ _____

Employee's Signature Date

Dependent's' Signature Date

(If applying for coverage and is over age 18)