Nippon Life Benefits®

Nippon Life Insurance Company
of America
P.O. Box 4387
Clinton, IA 52733

Evidence of Insurability for Group Disability Insurance - CA

Employer Name	Group Number
Your Name (Last, First, Middle Initial)	Social Security Number
Height _____ Weight _____ male ☐ female ☐	Date of Birth _____

1. Are you now actively employed on a full-time basis? ☐ yes ☐ no
   How many hours are you regularly scheduled to work per week? _____

2. In the last 5 years have you applied for any other disability insurance? ☐ yes ☐ no

3. To the best of your knowledge, have you been diagnosed or treated by a member of medical profession in the last 5 years for any of the following diseases or medical conditions:

3a. **IMMUNE SYSTEM** including but not limitedComplex (ARC), C Lymphadenopathy Syndrome, IDP, Immunodeficiency, Lupus, Varicose Veins, Kaposi's sarcoma, Hypogammaglobinemia, Systemic Lupus Erythamatosis (SLE), Hodgkin's Disease, Chronic Fatigue Syndrome Psoriasis or Scleroderma, not including HIV. ☐ yes ☐ no

3b. **PSYCHOLOGICAL** including but not limited to Alcoholism, Bipolar, Depression,Substance Abuse, Drug Dependency, Bulimia, Anorexia, Anxiety or Schizophrenia? Please indicate if hospitalized. ☐ yes ☐ no

3c. **BONES/MUSCLES/JOINTS** including but not limited to Bulging/Herniated Disk, Fibromyalgia, Joint Replacement, Muscular Dystrophy, Intervertebral Disc Degeneration, Thoracic/Lumbosacral Neuritis/Radiculitis, Chronic Pain, Spondylosis of Spine, or Spina Bifida? If joint Replacement, include the date of replacement. ☐ yes ☐ no

3d. **HEART/CIRCULATORY** including but not limited to chest pain, Angioplasty/Stent, Aneurysm, Bypass, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Heart Disease, Arteriosclerosis, Heart Murmur, High Blood Pressure, Hemophilia, Leukemia, Peripheral Artery Disease, Pacemaker/Defibrillator, Sickle Cell Anemia, Stroke Hemiparesis/Hemipelegia)/TIA, Congenital Factor Deficiency, Ventricular Tachycardia, Von Willibrand's Disease, Venous Thromboembolism, Diamond Blackfan Anemia, Thalassemia or Primary Nocturnal Hemoglobinuria. ☐ yes ☐ no

3e. **EYES/EARS/NOSE/THROAT** including but not limited to Acoustic Neuroma, Cleft Lip/Palate, Deviated Septum or Retinopathy. ☐ yes ☐ no

3f. **NEUROLOGICAL** including but not limited to ASL, Neuritis, Myasthenia Gravis, Cerebral Palsy, Multiple Sclerosis, Intracerebral/Subarachnoid Hemorrhage Paralysis/Hemiplegia/Quadriplegia Chronic Demyelinating Polyneuropathy, Acute Infective Polyneuritis, fainting, Muscular Dystrophy or Seizures, Convulsions, or Epilepsy. ☐ yes ☐ no

3g. **CANCER/TUMORS/GOITORS** provide details below regarding type, stage/level of advancement, if it has spread beyond the original site, radiation/chemotherapy, PHP, any surgeries completed/pending/expected. ☐ yes ☐ no

3h. **TRANSPLANTS** provide details below regarding transplant(s) completed, pending, expected or discussed, type of transplant (BMT, stem cell, specific organ) and any complications or signs of rejection. ☐ yes ☐ no

3i. **LIVER/KIDNEY/URINARY** including but not limited to Albumin in urine, Irritable Bladder Syndrome, Interstitial Cystitis, Urinary Incontinence, Kidney Stones, Benign Hypertrophy of Prostate, Fasciolosis, Hepatocellular Carcinoma (HCC), Malignant Hepatoma, Budd–Chiari syndrome, Cholangiocarcinoma, Gilbert–Meulengracht Syndrome, jaundice, Hepatitis (include information regarding type), Cirrhosis, Chronic Kidney Disease (CKD), Chronic Renal Disease, Renal Failure (list if chronic or end stage) or Dialysis (provide information below including type – hemo or peritoneal, Medicare eligible date and expected Medicare primary date). ☐ yes ☐ no

3j. **ARTHRITIS** including but not limited to Rheumatism , Osteoarthritis or Rheumatoid Arthritis. ☐ yes ☐ no

3k. **ENDOCRINE/METABOLISM** including but not limited to Diabetes, Neuropathy/Other Complications, Fabry's Disease, Gaucher's Disease/Lipidoses, Cushing's Syndrome, Growth Hormone Deficiency/Dwarfism, Sugar or casts in urine or Hurler's Disease. If Diabetic provide additional information below including whether it is controlled by diet, oral medication or insulin. ☐ yes ☐ no

3l. **LUNG/RESPIRATORY** including but not limited to blood spitting, Asthma, COPD/Emphysema (include information below on whether an oxygen tank is being used), Cystic Fibrosis, Chronic Bronchitis, Sarcoidosis, Sleep Apnea, Tuberculosis, Pneumonia or Post Inflammatory Pulmonary Fibrosis. ☐ yes ☐ no

3m. **INTESTINAL/STOMACH** including but not limited to Chronic diarrhea, Crohn's Disease, Diverticulitis/Diverticulum, Gallbladder Disease, Gastric Bypass, Pancreatitis, Ulcers, Indigestion, Blood or pus in urine, Rectum or Hernia or Ulcerative Colitis. ☐ yes ☐ no

3n. Any disease not listed above? ☐ yes ☐ no
If so, identify the disease here: _____

3o. Have you been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)? ☐ yes ☐ no

4. Are you at the present time taking medication or being treated by a medical professional for any disease or medical condition? ☐ yes ☐ no

5. If answers "yes" to any question listed above, please attach a description on additional paper, if needed, in which you identify the answer by number and explain medical histories in terms of the following, to the best of your knowledge and belief. You may offer any additional explanation you feel necessary.
   - A Dates and durations of attacks and/or episodes.
   - B The diagnosis of the medical professional. How did the physician, psychiatrist, psychologist, chiropractor, counselor or other medical practitioner describe the condition to you?
   - C What treatment, therapy, or medication was given?
   - D If applicable, date all treatment was discontinued or date of complete cure.
   - E Give names and addresses of all attending physicians, medical practitioners or specialists and/or facilities.

6. To the best of your knowledge, are you now pregnant? ☐ yes ☐ no

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For the purpose of evaluating my application for insurance, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me or my health, to give Nippon Life Insurance Company of America or any of its subsidiaries or affiliates or its reinsurers any such information. I also authorize Nippon Life Insurance Company of America or any of its subsidiaries or affiliates or its reinsurers to release any information regarding me or my health to the Medical Information Bureau, Inc.; or other life insurance companies in which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand that this information will be used by Nippon Life Insurance Company of America or any of its subsidiaries or affiliates to determine eligibility for insurance. This information includes information about drugs, alcoholism or mental illness. This authorization will be valid from the date signed for a period of 24 months. A photocopy of this authorization will be as valid as the original. I understand that I or my authorized representative may request a photocopy.

FRAUD WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The statements above are true to the best of my knowledge and belief, and I agree they shall form a part of the contract for which is applied. The insurance requested with this Evidence of Insurability form will not be effective until approved by the Home Office of Nippon Life Insurance Company of America. I hereby certify that I have received a copy of this form.

Employee Signature Required	Date Signed

NIPPON LIFE INSURANCE COMPANY OF AMERICA
INFORMATION PRACTICES NOTICE

To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, consumer reporting agencies, employers, or the Medical Information Bureau, Inc. (MIB). We will use the authorization you signed on the front side of this form when we seek this information.

MIB (MEDICAL INFORMATION BUREAU)

Information we collect about you is confidential. However, we may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such a member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. We may also release information about you to other insurance companies to whom you have applied for life or health insurance or made claim for benefits.

MIB will disclose any information it has about you at your request.

If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. The address of the MIB Information 50 Braintree Hill Park # 400, Braintree, MA 02184. MIB's telephone number is (781) 329-4500. Your request for correction will be handled by MIB in accordance with the procedures outlined in the Federal Fair Credit Reporting Act.

FEDERAL FAIR CREDIT REPORTING ACT PRENOTIFICATION

As part of the underwriting process, we may request an Investigative Consumer Report. These reports are prepared by independent reporting firms. They provide pertinent information about character, general reputation, personal characteristics, health, finances, and mode of living. This information may be obtained through personal interviews with friends, neighbors, associates, or others who know you.

If we request an Investigative Consumer Report, you have the right to ask to be interviewed personally. We will follow reasonable procedures to conduct such an interview. Upon your written request, you have the right to receive a copy of the report from the reporting company. If a report affects our decision not to approve your application as requested, we will provide you with the name and address of the reporting firm.

DISCLOSURE TO OTHERS

The information collected about you is confidential. We will not release any information about you without your authorization except to the extent necessary to conduct our business or as required or permitted by law.

YOUR RIGHTS

You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, please write us.

Nippon Life Insurance Company of America
Medical Underwriting – STD/LTD Coverage
P.O. Box 4387, Clinton, IA 52733

Please retain a copy for your records of the Health Statement and this Notice.