For company use only
Approved: _____
Date: _____

Health Net®
LIFE INSURANCE COMPANY

Evidence of Insurability Application *for* Group Life *Insurance*

Note: Please print in black ink. Any alteration to the printed copy will void this application.

<table>
<tr><td colspan="5">This applicant is:
☐ Addition to existing group
☐ Change of benefits
Group number: _____
Application is made for:
☐ Basic Life amount: _____ ☐ Supplemental Life amount: _____
☐ Dep. Life amount: _____ ☐ Other: _____</td></tr>
<tr><td colspan="5">Name of applicant:</td></tr>
<tr><td colspan="5">If dependent, relationship to employee:</td></tr>
<tr><td colspan="5">Home address:</td></tr>
<tr><td colspan="3">City:</td><td>State:</td><td>ZIP:</td></tr>
<tr><td>Home phone number:
( )</td><td colspan="2">Date of birth (mm/dd/yyyy):
/ /</td><td>Sex:</td><td>Social Security number:
– –</td></tr>
<tr><td colspan="5">Your occupation (in detail):</td></tr>
<tr><td colspan="5">Employer's name/address:</td></tr>
<tr><td>Height:</td><td>Weight:</td><td colspan="3">Have you gained or lost more than 20 pounds in the last year? ☐ Yes ☐ No
If "Yes": ☐ Gained ☐ Lost _____ pounds (give details)</td></tr>
<tr><td colspan="2">Full name of your regular physician:</td><td colspan="3">Date/reason last consulted?</td></tr>
<tr><td colspan="5">Full address of your regular physician:</td></tr>
<tr><td colspan="3">City:</td><td>State:</td><td>ZIP:</td></tr>
</table>

(continued)

Life Premium Accounting and Eligibility
PO Box 9103, Van Nuys, CA 91409-9103
1-800-865-6288

CA116480 (10/14)

Health questions (Answer all questions – Attach separate sheet if necessary.)	
1. If employed, are you actively at work at least 30 hours a week?	☐ Yes ☐ No
2. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury? If "Yes," give details below.	☐ Yes ☐ No
3. Are you now under regular medical observation or taking medical treatment? If "Yes," give details below.	☐ Yes ☐ No
4. Within the last five years, have you consulted a member of the medical profession for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests? If "Yes," give details below.	☐ Yes ☐ No
5. To the best of your knowledge have you had or been told you have acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)?	☐ Yes ☐ No
6. Please check either "Yes" or "No" if you have ever had or been treated for, or counseled or advised by a member of the medical profession that you have or may have, any of the following. If "Yes," give details below.	☐ Yes ☐ No

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Diabetes or albumin or sugar in urine	☐	☐	Cancer or tumors	☐	☐
Rheumatic fever	☐	☐	Disorder of the stomach or intestines or liver	☐	☐	Lung disorder	☐	☐
Heart murmur	☐	☐	Nervous disorder or epilepsy	☐	☐	Kidney disease	☐	☐
Paralysis	☐	☐	Heart disease, stroke or other circulatory disorders	☐	☐	Back disorder	☐	☐
Chest pain	☐	☐	Sexually transmitted diseases	☐	☐			

Condition	*Date*	*Remaining effects*	*Physician's full name/address*

I hereby state that the foregoing statements and answers made by me on behalf of myself are complete and true, to the best of my knowledge and belief, that they are correctly and fully recorded, and that no material circumstance or information has been withheld or omitted concerning myself. I agree that the answers and statements herein shall form a part of the contract. I understand that any misstatement or failure to report information may be used as the basis of a recision of insurance for myself. I understand that if medical records are necessary to determine my insurability, they will be provided by me at my expense. I also understand that insurance will not be in force until the application is approved in writing by Health Net Life Insurance Company. I AGREE that a photocopy of this AUTHORIZATION shall be as valid as the original and that this AUTHORIZATION will be valid from the date signed below for a period of twenty-four (24) full months, or less if required by applicable state law. Furthermore, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company or other health care provider, or the Medical Information Bureau, that has any medical records or knowledge of me, to give to Health Net Life Insurance Company, its reinsurers or their legal representative, any such information, including, without limitation, information relating to mental health treatment, chemical dependency, and sexually transmitted diseases.

Signature of applicant: _____ Date: _____

(and parent if applicant is under age 18)

HN1035

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Cut off – for applicant's reference

Notice of exchange of information

Thank you for enrolling for Group Life Insurance with Health Net Life Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability. Information regarding your insurability will be treated as confidential. Health Net Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is MIB, Inc., 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734; telephone number (781) 751-6000.

Health Net Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.