State Farm Life Insurance Company
1 State Farm Plaza, Bloomington, IL 61710-0001

Statement of Insurability for Group Term Life Insurance Instructions

Providing Evidence of Insurability for Group Life Insurance

Evidence of insurability is required for Group Term Life based on the group size, amount of coverage, or if you previously waived or cancelled Group Term Life coverage on yourself, your spouse and/or your dependents. The application will be reviewed and insurability determined. If approved, a Record Card will be required and the effective date of coverage will be based on your group plan.

Completing the Statement of Insurability for Group Term Life Insurance Instructions

Before completing, please verify the attached Statement of Insurability for Group Term Life Insurance application is for the state in which you reside.

This application is for the following states: **AL, AK, AZ, AR, CT, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MS, MO, NE, NV, NH, NJ, NC, OH, OR, PA, SC, TN, TX, UT, WA, WV and WY**

The completed forms may be mailed or faxed to State Farm.

State Farm Life Insurance Company
Commercial Group Life Unit
P.O. Box 2380
Bloomington, IL 61702-2380

Fax number: 309-766-6124

(If the forms are faxed, the original does NOT need to be mailed.)

EMPLOYEES/MEMBERS COMPLETE SECTIONS 1-5. COMPLETE SECTIONS 6-8 IF APPLYING FOR COVERAGE FOR YOUR SPOUSE OR CHILDREN.

Please include the group policy or plan number. If the group policy has not been issued, indicate the policy is pending.

*The **Employee's signature** is always required:*

1. At the bottom of page 5 of the application *"Proposed Insured signature"*
2. On Form 1008524 "Acknowledgment and Authorization" *"Proposed Insured 1 signature"*

*If a **Spouse** is applying for coverage, their signature is required on:*

1. Form 1008524 "Acknowledgment and Authorization" *"Proposed Insured 2 signature"*

The last page of the packet titled "NOTICES" should be retained by the Employee.

Statement of Insurability for Group Term Life Insurance

State Farm Life Insurance Company
1 State Farm Plaza, Bloomington, IL 61710-0001

1 Policyholder or Prospective Policyholder Information

Policyholder name

Policy or plan number

2 Employee or Member Personal Information

Last name | First name | Middle name | SSN/ITIN

Address

City | State | ZIP code | Insurance amount

Job title | Date hired (MM/DD/YYYY) | Marital status

Date of birth (MM/DD/YYYY) | Age | State of birth | Sex: ◯ Male ◯ Female | Height (feet/inches) / | Weight (lbs)

3 Proposed Insured (Employee/Member) Medical Information

If yes, please provide explanations in Section 5

a. Have you ever tested positive for or been diagnosed by a member of the medical profession with:

- Human Immunodeficiency Virus (HIV) ◯ Yes ◯ No
- Acquired Immune Deficiency Syndrome (AIDS) ◯ Yes ◯ No

b. In the last **10 years**, have you been diagnosed, treated, or been given advice by a member of the medical profession for:

- high blood pressure, stroke or transient ischemic attack (TIA), heart murmur, chest pain, or heart attack? ◯ Yes ◯ No
- anemia or blood disorder; tumor, cancer, or lymph gland disorder? ◯ Yes ◯ No
- mental, nervous, or convulsive disorder or epilepsy? ◯ Yes ◯ No
- pneumonia, emphysema or asthma? ◯ Yes ◯ No
- ulcer, colitis, liver, or intestinal disorder? ◯ Yes ◯ No
- diabetes, arthritis, sexually transmitted disease, or kidney disease (excluding HIV, AIDS and ARC)? ◯ Yes ◯ No

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c. In the last **5 years**, have you ever:

- applied for or received disability benefits? ○ Yes ○ No
- been diagnosed, treated or been given advice by a member of the medical profession for any loss of sight or hearing or an injury to your neck, back, arm or leg? ○ Yes ○ No

d. In the last **5 years**, have you for any reason not previously explained:

- had or been advised by a member of the medical profession to have treatment or a test in any medical facility such as a lab, clinic, or hospital? ○ Yes ○ No
- seen a doctor, any member of the medical profession, or psychologist, had medication prescribed, or been told surgery was necessary? ○ Yes ○ No
- used cocaine, marijuana, or any other controlled substance or narcotic not prescribed by a doctor or member of the medical profession, been treated or counseled by a member of the medical profession for alcohol or drug use, or been advised to seek treatment or counsel for alcohol or drug use? ○ Yes ○ No

4 Life Style and Driving Information

If yes, please provide explanations in Section 5

a. In the last **3 years**, have you engaged in any of the following?

- Aviation (other than as a passenger or commercial airline crew) ○ Yes ○ No
- Sky diving (more than 1 time), BASE jumping, hang gliding ○ Yes ○ No
- Mountain/rock climbing ○ Yes ○ No
- SCUBA diving (depths greater than 100 feet) ○ Yes ○ No
- Vehicle racing ○ Yes ○ No

b. In the last **3 years**, have you been convicted of or pleaded guilty to any moving violations or driving under the influence of alcohol or drugs? ○ Yes ○ No

5 Explanations

(Please designate section, question, provide diagnoses, dates, durations, and names and addresses of all doctors and medical facilities.)

6 Spouse/Dependents Personal Information

To be completed by Proposed Insured (Employee/Member) only if dependent coverage is being applied for:

Spouse

Last name _____ First name _____ Middle name _____

SSN/ITIN _____ Date of birth (MM/DD/YYYY) _____ Age _____ State of birth _____

Date married (MM/DD/YYYY) _____ Sex: ○ Male ○ Female Height (feet/inches) _____/_____ Weight (lbs) _____

Occupation (give exact duties) _____

Dependent Children

Name (If Last Name different, explain)	Relationship to Employee/Member	Birth Date (MM/DD/YYYY)

7 Spouse/Dependents Medical Information

If yes, please provide name of dependents and explanations in Section 8

a. Has your spouse ever tested positive for or been diagnosed by a member of the medical profession with:

- Human Immunodeficiency Virus (HIV) ○ Yes ○ No
- Acquired Immune Deficiency Syndrome (AIDS) ○ Yes ○ No

b. In the last **10 years**, has your spouse been diagnosed, treated, or been given advice by a member of the medical profession for:

- high blood pressure, stroke or transient ischemic attack (TIA), heart murmur, chest pain, or heart attack? ○ Yes ○ No
- anemia or blood disorder; tumor, cancer, or lymph gland disorder? ○ Yes ○ No
- mental, nervous, or convulsive disorder or epilepsy? ○ Yes ○ No
- pneumonia, emphysema or asthma? ○ Yes ○ No
- ulcer, colitis, liver, or intestinal disorder? ○ Yes ○ No
- diabetes, arthritis, sexually transmitted disease, or kidney disease (excluding HIV, AIDS and ARC)? ○ Yes ○ No

c. In the last **5 years**, has your spouse for any reason not previously explained:

- had or been advised by a member of the medical profession to have treatment or a test in any medical facility such as a lab, clinic, or hospital? ○ Yes ○ No

- seen a doctor, any member of the medical profession, or psychologist, had medication prescribed, or been told surgery was necessary? ○ Yes ○ No
- used cocaine, marijuana, or any other controlled substance or narcotic not prescribed by a doctor or member of the medical profession, been treated or counseled by a member of the medical profession for alcohol or drug use, or been advised to seek treatment or counsel for alcohol or drug use? ○ Yes ○ No

d. In the last **10 years**, have any of the children named in Section 6 been diagnosed, treated, or been given advice by a member of the medical profession for any of the following:

- a birth defect, mental disorder, or impairment of sight, hearing, or speech? ○ Yes ○ No
- asthma, seizure, diabetes, or kidney disease? ○ Yes ○ No
- heart murmur, anemia, leukemia, or cancer? ○ Yes ○ No
- in the last **3 years**, seen a doctor or member of the medical profession for any reason not previously explained excluding any routine physical examination with normal findings? ○ Yes ○ No

e. Have any children named in Section 6, ever tested positive for or been diagnosed by a member of the medical profession with:

- Human Immunodeficiency Virus (HIV) ○ Yes ○ No
- Acquired Immune Deficiency Syndrome (AIDS) ○ Yes ○ No

8 Explanations

(Please designate section, question, provide diagnoses, dates, durations, and names and addresses of all doctors and medical facilities.)

9 Agreements

I state that the information in this application is true and complete to the best of the Proposed Insured's knowledge and belief. It is agreed that the Company can investigate the truth and completeness of such information during the contestability period. No coverage will be effective until:

1. The Effective Date as defined in the group life insurance policy, and
2. The date this application is approved by State Farm Life Insurance Company.

Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Proposed Insured signature

Date (MM/DD/YYYY)

SIGNATURE

Witness to Proposed Insured's signature

Date (MM/DD/YYYY)

SIGNATURE

At

City

State

Acknowledgment and Authorization

State Farm Life Insurance Company
1 State Farm Plaza, Bloomington, IL 61710-0001

Acknowledgment

I have received the Notices and the Acknowledgment and Authorization wording.

Authorization

I authorize any source having information about me or my dependents to give State Farm Life Insurance Company (State Farm), its contractors, reinsurers, or its representatives all information available within the last ten (10) years as to health history, diagnosis, treatment or prognosis with respect to any physical or mental condition and non-medical information including, but not limited to:

- Employment history
- Income
- Other insurance coverage

"Source" includes any doctor, hospital, clinic, U.S. Veteran's Affairs (VA) Hospital, mental health facility, or any other medically related facility, insurance company, consumer reporting agency and MIB, Inc.

I authorize State Farm Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc.

I understand that State Farm will use any information they obtain to determine my eligibility for insurance and may also use it for insurance research purposes.

Information obtained using this Authorization may later be redisclosed and may not be protected under the Health Insurance Portability and Accountability Act of 1996. However, other applicable state laws and protections will still apply.

I understand that:

- I may revoke this Authorization by providing a written request to State Farm, except when State Farm has taken action based on this Authorization.
- Revoking this Authorization will cause my application to be declined.
- I may refuse to sign this Authorization, but doing so will cause my application to be declined.
- My medical sources cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

This Authorization is valid for two (2) years from the date of signature. Non-medical information may be shared with State Farm Mutual Automobile Insurance Company and its affiliates or non-affiliated third parties as permitted or required by law. No MIB information will be released to another consumer reporting agency.

A copy of this Authorization is as valid as the original. I understand I and/or my authorized representative have the right to receive a copy of this Authorization.

Proposed Insured 1 signature

Date (MM/DD/YYYY)

SIGNATURE

Maiden or Former name

Proposed Insured 2 signature

Date (MM/DD/YYYY)

SIGNATURE

Maiden or Former name

Doc type 33

Notices

State Farm Life Insurance Company
1 State Farm Plaza, Bloomington, IL 61710-0001

Notices

INFORMATION PRACTICES

The application requests personal information about the persons proposed for coverage. We may collect personal information from persons other than the individual or individuals applying for coverage. Such personal information as well as other personal or privileged information subsequently collected may, in certain circumstances, be disclosed to third parties without your authorization as permitted by law. If you would like additional information about the collection and disclosure of personal information, please contact your State Farm agent. You may also act upon your right to see and correct any personal information in your State Farm Life Insurance Company (State Farm) files by writing your State Farm agent to request this access.

MIB NOTICE

Information regarding your insurability will be treated as confidential. State Farm, or its reinsurers may, however, make a brief report to MIB, Inc. This is a non-profit membership organization of life insurance companies which 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, upon request, will supply such a company with the information it may have 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 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, telephone number 866-692-6901.

State Farm, 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.

Acknowledgment and Authorization

In connection with the application to State Farm for life insurance on your life, you have signed the following Acknowledgment and Authorization.

Acknowledgment

I have received the Notices and the Acknowledgment and Authorization wording.

Authorization

I authorize any source having information about me or my dependents to give State Farm Life Insurance Company (State Farm), its contractors, reinsurers, or its representatives all information available within the last ten (10) years as to health history, diagnosis, treatment or prognosis with respect to any physical or mental condition and non-medical information including, but not limited to:

- Employment history
- Income
- Other insurance coverage

"Source" includes any doctor, hospital, clinic, U.S. Veteran's Affairs (VA) Hospital, mental health facility, or any other medically related facility, insurance company, consumer reporting agency and MIB, Inc.

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I understand that State Farm will use any information they obtain to determine my eligibility for insurance and may also use it for insurance research purposes.

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- Revoking this Authorization will cause my application to be declined.
- I may refuse to sign this Authorization, but doing so will cause my application to be declined.
- My medical sources cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
- This Authorization is valid for two (2) years from the date of signature. Non-medical information may be shared with State Farm Mutual Automobile Insurance Company and its affiliates or non-affiliated third parties as permitted or required by law. No MIB information will be released to another consumer reporting agency.

A copy of this Authorization is as valid as the original. I understand I and/or my authorized representative have the right to receive a copy of this Authorization.