AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate

Workplace Division

For AHL Home Office use only

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Check appropriate box(es)

☐ **Group Voluntary Accident**
☐ **Group Voluntary Cancer/Specified Disease**
☐ **Group Voluntary Hospital Indemnity**
☐ **Heritage Choice Dental** (enrollment only)

Notes

GENERAL INFORMATION SECTION

(Please complete entire section for all coverages)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc) First M.I.	SEX	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDAY (MM/DD/YEAR)	PHONE NUMBER	EMPLOYER	DATE OF HIRE (MM/DD/YEAR)
GROUP POLICY NAME (If different from the employer name)	HEIGHT	WEIGHT	CURRENT EARNINGS $_____ (also check appropriate box) ☐ Hourly ☐ Weekly ☐ Bi-weekly (26) ☐ Monthly ☐ Semi-monthly (24) ☐ Annually
JOB TITLE	PLANT OR DIVISION		
BENEFICIARY'S NAME (Last, First, M.I.)	RELATIONSHIP		

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?

Group Voluntary Cancer/Specified Disease ☐ Yes ☐ No **Heritage Choice Dental** ☐ Yes ☐ No

Group Voluntary Hospital Indemnity ☐ Yes ☐ No **Group Voluntary Accident** ☐ Yes ☐ No

If "Yes", please complete the following: Qualifying Event _____

Date of Qualifying Event _____ Current Certificate Number _____

Do you currently have any of the following individual products with AHL?

Cancer ☐ Yes ☐ No Accident ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

If you answered "Yes" to any of the products, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Choose Plan(s): Accident	Cancer	Hospital	Dental	Dependent's Name(s) (Last, First, M.I.)	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number
				Spouse			
				Child			
				Child			
				Child			
				Child			

Premium/Billing Mode	Case Number	Agent Number	Percentage Credit
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other			
Date of First Deduction _____	Employee Number		
Cash With Application _____	Situs State		

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SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

Accident ☐ Yes ☐ No	Base Units _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Optional Disability Riders for Employee

☐ Off the Job Accident
☐ On and Off the Job Accident
☐ Off the Job Accident and Sickness
☐ On and Off the Job Accident and Sickness

Optional Disability Riders for Spouse

☐ On and Off the Job Accident for Insured Spouse*
☐ On and Off the Job Accident and Sickness for Insured Spouse*

***Available only when family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.**

Disability Rider Units

Employee _____

Spouse _____

Cancer/Specified Disease ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option ☐	Intensive Care Option ☐	Cancer Screening Option ☐
Units				1			

Hospital Indemnity ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option ☐	Prescription Drug Option ☐	Disability Rider ☐	Life Rider ☐
Units						1	

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No

If "Yes", please enter the date coverage effective _____

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P1NG1 P1NG2 P1NG3

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected. Does not apply to Dental.)

Non-Medical Questionnaire		
All Coverages	1. Is any person to be insured actively at work now and has he/she worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No
If any of the questions 2-8 below are answered "yes", please list the required health history on the next page.		
All Coverages	2. Is any person to be insured been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	☐ Yes ☐ No
Accident	3. Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If "yes", provide additional details on the next page.	☐ Yes ☐ No
Riders Only — **Accident & Sickness Disability Riders**	4a. Has any person to be insured, within the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	☐ Yes ☐ No
	b. Has any person to be insured been diagnosed with hypertension or high blood pressure?	☐ Yes ☐ No
	c. If the answer to [4b] is yes, in the last year has he/she had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
	d. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	☐ Yes ☐ No
	e. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	☐ Yes ☐ No
Cancer	5. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	☐ Yes ☐ No
Intensive Care Optional Benefit (Cancer Only)	6a. Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	☐ Yes ☐ No
	b. Has any person to be insured been diagnosed with hypertension or high blood pressure?	☐ Yes ☐ No
	c. If the answer to [6b] is yes, in the last year has he/she had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
Hospital Indemnity	7a. Is any person to be insured currently being treated for, or has any person ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor; a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes?	☐ Yes ☐ No
	b. Has any person to be insured been diagnosed with hypertension or high blood pressure?	☐ Yes ☐ No
	c. If the answer to [7b] is yes, in the last year has he/she had either a: (1) systolic blood pressure reading higher than 150 more than once or (2) diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
Hospital Indemnity	8. Has any person to be insured, within the last 3 years, been treated for, or been told by a member of the medical profession that he or she has: epilepsy; hepatitis; muscular dystrophy or muscular sclerosis or any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs; paralysis; been counseled for alcohol or drug abuse; or had any medical or surgical procedure recommended but not done at this time?	☐ Yes ☐ No

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REQUIRED HEALTH HISTORY

***Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

Use this space for any additional explanation of questions 2-8 on page 3. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers contained on this form are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to American Heritage Life Insurance Company as an inducement to grant insurance, and I understand that American Heritage Life Insurance Company may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. **FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.** · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this Evidence of Insurability form is signed. · **I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my family or our health to disclose to American Heritage Life Company any such information. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so. · **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested above. This signature also verifies the accuracy of the information on this enrollment form. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

IMPORTANT NOTICE ABOUT PRIVACY:
In processing your application, an investigative report may be made. Information obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.
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