AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Group Voluntary Critical Illness

This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.) First M.I.	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION	DATE HIRED (MM/DD/YEAR)
EMPLOYEE'S EMAIL	OCCUPATION	PLANT OR DIVISION	

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.? ☐ Yes ☐ No

If "Yes", indicate type of change: _____

Date of change _____ Current Certificate Number _____

1. Do you currently have an individual Critical Illness product with AHL? ☐ Yes ☐ No
   If "Yes", please enter the Policy Number _____
   Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____
2. Do you currently have comprehensive health benefits from either an insurance policy or an HMO plan? ☐ Yes ☐ No
   If you have answered "No", you may not apply for Group Voluntary Critical Illness Coverage.

DEPENDENT COVERAGE SECTION

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

Dependent's Name(s) (Last, First, M.I.)	**Relationship**	**Sex**	**Date of Birth** (MM/DD/YEAR)	**Social Security Number**

SELECTION OF COVERAGE SECTION

Critical Illness ☐ Yes ☐ No	☐ My Lifeline ☐ New Generation	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only** SET ID _____

Basic Benefit Amount $ _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.	Wellness Benefit Units _____	Critical Illness Cancer Option ☐	Recurrence Option ☐

Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No

If so, who and what type? _____

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

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected.)

Non-Medical Questionnaire		
1.	Is the proposed 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
Level 1 - Evidence of Insurability **If any of the questions below are answered "yes", please list the required health history on the next page.**		
2.	Is any person to be insured now being treated, or ever been treated or diagnosed, by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.**	☐ Yes ☐ No
3a.	Has any person to be insured in 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; any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs, pancreas or back (including neck); or paralysis?	☐ Yes ☐ No
b.	Is any person to be insured now being treated for, or ever been treated for: a stroke or transient ischemic attack (TIA); a heart attack; a heart condition; heart trouble; any abnormality of the heart; or any artery disease?	☐ Yes ☐ No
c.	Has any person to be insured been diagnosed with hypertension or high blood pressure?	☐ Yes ☐ No
d.	If the answer to 3c 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
e.	Has any person to be insured in the last 2 years been treated for or counseled for alcohol or drug abuse?	☐ Yes ☐ No
f.	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
g.	Has any person to be insured received any advice, treatment or consultation for Alzheimer's Disease, dementia, senility or organic brain syndrome?	☐ Yes ☐ No
Cancer: Evidence of Insurability, if Cancer Option selected		
4.	Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer (except basal cell skin cancer) or any malignancy which includes: carcinoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	☐ Yes ☐ No
Level 2 - Additional Evidence of Insurability, if required		
5.	Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	☐ Yes ☐ No
6.	Are any persons to be insured currently taking any prescribed medication?	☐ Yes ☐ No
7.	In the past 5 years has any person to be insured received medical advice, sought treatment or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this Evidence of Insurability form?	☐ Yes ☐ No
8.	Please indicate height and weight	Employee Height: Weight:
		Spouse Height: Weight:
Level 3 - Additional Evidence of Insurability, if required		
9.	Please indicate the names and addresses of all physicians for each person to be insured; use the space provided on page 3 for additional explanations.	

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

REQUIRED HEALTH HISTORY

List physician's name, address and telephone number

Name	Nature of Illness/Injury or Medical Attention/Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic

Use this space for any additional explanation of questions 2-9 on page 2. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: www.allstateatwork.com/mybenefits.

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my Certificate, free of charge, by calling, toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

☐ YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.

☐ NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.

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 Enrollment and Evidence of Insurability Form. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this Enrollment and 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 health to give to American Heritage Life Insurance Company, it's subsidiaries or its reinsurers, any information. I acknowledge receipt of the Important Notice About Privacy. 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 Insurance Company 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 coverage(s) requested above. This signature also verifies the accuracy of the information on this Enrollment and Evidence of Insurability 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)

Dependent's Signature _____ Signed at _____ Date Signed _____
(Required for Spouse or Child over 18) (City and State)

IMPORTANT NOTICE ABOUT PRIVACY:

In processing your application, an investigative report may be made. Information is 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.

GCI-IN