Allstate Benefits

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

☒ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only

GENERAL INFORMATION

Employee's/Payor's/Owner's (Certificateholder) Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union: DNP of America / Date Hired	Occupation	Plant Or Division	
Primary Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		
Contingent Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use*
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No
						^ ☐ Yes ☐ No
						^ ☐ Yes ☐ No
						^ ☐ Yes ☐ No

*Has anyone to be insured used tobacco in the last 12 months? (**If applying for Life or Critical Illness. ^For dependents ages 19 and older, if applying for Life.)

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

Accident ☐ Yes ☐ No
Cancer/Specified Disease ☐ Yes ☐ No
Critical Illness ☐ Yes ☐ No

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

Date of Qualifying Event _____ Current Certificate Number(s) _____

Do you currently have any of the following individual coverages with American Heritage Life Insurance Company (AHL)?

Accident ☐ Yes ☐ No Cancer ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No

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

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

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	83156		NC

(EOI L70PA)
ABJ4580NC2

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SELECTION OF COVERAGE

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

Accident (GVAP2) (Off the Job Accident) ☐ Yes ☐ No	Base Units 2	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Mode Premium $ _____	**Home Office Use Only**
☒ Benefit Enhancement Option Units 2	☐ Enhanced Family Fracture Option	☒ Outpatient Physician's Rider Units 4			

Cancer/Specified Disease (GVCP3) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Mode Premium $ _____	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option	Wellness Option
Units	2	4	2	1	6	4

Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Mode Premium $ _____	**Home Office Use Only**
Basic Benefit Amount $ 10,000 If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.		☒ Supplemental Critical Illness Option II		☒ 2nd Event Initial Critical Illness Option

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)
Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

Eligibility Question		EE	SP	CH
Cancer & Critical Illness	1. Is any person to be insured (employee and the employee's spouse if applying for life and/or accident with sickness disability rider) actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐Y ☐N	☐Y ☐N	N/A

If any of the questions below are answered "yes", please list the required health history on page 4.

Underwriting Questions		EE	SP	CH
Cancer & Critical Illness	2. Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness	3. Has any person to be insured, in the last year, been diagnosed by a member of the medical profession with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer, Cancer Initial Diagnosis Option	4a. Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	4b. If the answer to 7a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	4c. If the answer to 7a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 7b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness	5. Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following? • Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy) • Chronic Fatigue Syndrome • Diabetes • Emphysema • Fibromyalgia • Heart Disease • Liver Disease • Lung Disease • Lupus • Optic Neuritis • Parkinson's Disease • Paralysis • Rheumatoid Arthritis	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness	6. Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a member of the medical profession, but not done at this time?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness Supplemental Benefits Option	7. Has any person to be insured, in the last 10 years, been diagnosed with or received any advice, treatment or consultation by a member of the medical profession for any of the following? • Alzheimer's Disease, dementia, senility or organic brain syndrome • Macular degeneration, glaucoma, optic neuritis, or cataracts • An average hearing threshold sensitivity for air conduction of 40 decibels or greater	☐Y ☐N	☐Y ☐N	☐Y ☐N

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

If any of the questions below are answered "yes", please list the required health history in Question 10 below.

	Underwriting Questions (Continued)	EE	SP	CH
Cancer	8. Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any of the following?	☐Y ☐N	☐Y ☐N	☐Y ☐N

- Addison's Disease
- Brucellosis
- Cerebrospinal meningitis
- Cystic Fibrosis
- Encephalitis
- Hansen's Disease
- Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
- Legionnaire's Disease
- Lou Gehrig's Disease (ALS)
- Lyme Disease
- Muscular Dystrophy
- Multiple Sclerosis
- Myasthenia Gravis
- Osteomyelitis
- Primary Biliary Cirrhosis
- Primary Sclerosing Cholangitis
- Reye's Syndrome
- Rocky Mountain Spotted Fever
- Sickle Cell Anemia
- Systemic Lupus Erythematosus
- Tetanus
- Tuberculosis
- Thallasemia
- Tularemia
- Typhoid Fever

Critical Illness	9. Provide Height and Weight of Proposed Insured: Height: Weight:
Required Health History	10. Provide health history for any "Yes" answers to the Underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number:

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance, including all documents accompanying my certificate(s) of insurance. If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my certificate and accompanying documents at: www.allstatebenefits.com/mybenefits.

☒Y ☐N

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) of insurance, to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence at: www.allstatebenefits.com/mybenefits.

☒ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. 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(s) of insurance, 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.

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **UNDERSTANDING.** I understand that: if premiums for the coverage(s) is (are) to bepaid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the "effective date" for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwisemodify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in thisapplication. 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. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, thenecessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFEAND CRITICAL ILLNESS).** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau (MIB, Inc.) or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. I or my representative may request a copy of this authorization. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Signature of Owner, if other than Insured _____

Signature of Employee/Payor, if not Insured or Owner _____

Producer's Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer:			%
Soliciting Producer: Mark Belue	0LE30		100 %
			%
			%
			%