AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate
Workplace Division

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

Check appropriate box(es)

- ☐ **AHL minimedical®** (enrollment only)
- ☐ **Short-Term Disability**
- ☐ **Long-Term Disability**
- ☐ **Life/Accidental Death & Dismemberment**
- ☐ **Heritage Choice Dental** (enrollment only)

For AHL Home Office use only

Group No.	Account	Location
Dep Code E S C F	**Smoker** EE **Y** or **N** SP **Y** or **N**	**Issue State**
EFFECTIVE DATE		

For AHL Home Office use 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/YR)	PHONE NUMBER	EMPLOYER	DATE OF HIRE (MM/DD/YR)
JOB TITLE	PLANT OR DIVISION	CURRENT EARNINGS $_____ (also check appropriate box) ☐ Hourly ☐ Weekly ☐ Monthly ☐ Bi-weekly (26) ☐ Semi-monthly (24) ☐ Annually	
GROUP POLICY NAME (If different from the employer name)			
BENEFICIARY'S NAME (Last, First, M.I.)		RELATIONSHIP	

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?

AHL minimedical® ☐ Yes ☐ No **Short-Term Disability** ☐ Yes ☐ No

Long-Term Disability ☐ Yes ☐ No **Life/Accidental Death & Dismemberment** ☐ Yes ☐ No

Heritage Choice Dental ☐ Yes ☐ No

If "Yes", indicate type of change _____

Date of change (MM/DD/YR) _____ Current Certificate Number _____

DEPENDENT COVERAGE SECTION

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

Choose Plan(s) Medical	Life	Dental	Dependent's Name (Last, First, M.I.)	Sex	Date of Birth (MM/DD/YR)	Social Security Number
			Spouse			
			Child			
			Child			
			Child			

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SELECTION OF COVERAGE SECTION

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

AHL minimedical® ☐ Yes ☐ No	☐ Value ☐ Ultra	☐ Employee Only ☐ Employee + 1 ☐ Family	Section 125 ☐ Yes ☐ No	**Home Office Use Only** SET ID _____

If you did not elect MEDICAL coverage, is this because of other health coverage? ☐ Yes ☐ No

Notice of Preexisting Conditions Exclusion: This plan imposes a Preexisting Conditions Exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to our Customer Service Department at 1-800-937-7039.

Short-Term Disability ☐ Yes ☐ No	Benefit Amount per month	Monthly Premium	**AHL Home Office Use Only** SET ID/PLAN ID **ACTIV/STD** _____ and/or **EMPLR/STD** _____ and/or (other) _____

Long-Term Disability ☐ Yes ☐ No	Benefit Amount per month	Monthly Premium	**AHL Home Office Use Only** SET ID/PLAN ID **ACTIV/LTD** _____ and/or **EMPLR/LTD** _____ and/or (other) _____

Life/Accidental Death & Dismemberment Employee ☐ Yes ☐ No	Benefit Amount	Monthly Premium	**AHL Home Office Use Only** SET ID/PLAN ID **ACTIV/AD&D** _____ **LIFE** _____ and/or **EMPLR/AD&D** _____ **LIFE** _____ and/or (other) _____

Dependent Coverage (If Applicable)

Spouse ☐ Yes ☐ No	Benefit Amount (Cannot exceed 50% of Employee Amount)	Monthly Premium	**AHL Home Office Use Only** SET ID/PLAN ID **ACTIV/AD&D** _____ **LIFE** _____ and/or **EMPLR/AD&D** _____ **LIFE** _____ and/or (other) _____
Child(ren) ☐ Yes ☐ No	Benefit Amount (Cannot exceed 50% of Employee Amount)	Monthly Premium	**AHL Home Office Use Only** SET ID **ACTIV** or **EMPLR** or (other) _____ PLAN ID **OPTA** / **OPTB** / **OPTC** / **OPTD** / **OPTE**

Have you used tobacco in any form in the last 12 months? **EMPLOYEE** ☐ Yes ☐ No **SPOUSE** ☐ Yes ☐ No

If "Yes", indicate the type and date last used: Employee type _____ date last used (MM/DD/YR) _____

Spouse type _____ date last used (MM/DD/YR) _____

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ 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 (MM/DD/YR) _____	**AHL Home Office Use Only** SET ID **ACTIV** or **EMPLR** or _____ PLAN ID **P1NG1** **P1NG2** **P1NG3**

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY SECTION - PLEASE COMPLETE

(Coverage will not be considered unless ALL questions are answered. Does not apply to AHL minimedical® or Dental)

1. For ALL persons applying for coverage who require evidence of insurability, please answer the following:

Name (Last, First, M.I.)	Relationship to Employee	Occupation	Date of Birth (MM/DD/YEAR)	Place of Birth	Sex	Height (ft. & in.)	Weight (lbs.)
	Self						
	Spouse						
	Child						
	Child						
	Child						

Please explain all "Yes" answers in the space provided on page 4. In your explanations, identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of applicable physician(s) and/or hospital(s).

2. a)	Has any person to be insured had any change in weight in the past year? If "Yes", give the amount of gain or loss and the cause of change.	☐ Yes ☐ No
b)	Has any person to be insured been absent from work or unable to carry on normal activities due to illness or injury during the past 6 months?	☐ Yes ☐ No
c)	Has any person to be insured had this coverage before?	☐ Yes ☐ No
d)	Has any person to be insured ever been or currently insured under any other policy issued by American Heritage Life Insurance Company? If "Yes", give the Group No. or other Policy No. _____	☐ Yes ☐ No
e)	Has any person to be insured ever had a request for coverage declined, postponed, canceled, or been charged an extra rate for life, accident or health insurance or received such a policy of insurance other than exactly as applied for?	☐ Yes ☐ No
f)	Has any person to be insured ever made claim for, or received benefits from a pension, or other payment because of an injury, sickness or disability?	☐ Yes ☐ No
3. a)	Has any person to be insured been advised or recommended by a physician of a surgical or medical treatment that has not been done yet?	☐ Yes ☐ No
b)	Does any person to be insured have an appointment to visit a physician within the next 30 days?	☐ Yes ☐ No
c)	If any person is female, is she now pregnant? Will any female to be insured visit a physician within the next 14 days to determine if she is pregnant?	☐ Yes ☐ No
4. a)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: a stroke; rheumatic fever; heart murmur; heart attack; a heart condition; heart trouble or other disorder of the heart or blood vessels (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 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 been treated for, or been told by a member of the medical profession that he/she has or had: bronchitis; pleurisy; asthma; emphysema; tuberculosis or other chronic respiratory disorder; or a tonsillectomy or adenoidectomy?	☐ Yes ☐ No
e)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: epilepsy; muscular dystrophy; polio; osteomyelitis; or multiple sclerosis?	☐ Yes ☐ No
f)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: jaundice; ulcer; hernia; hemorrhoids, appendicitis; colitis; Crohn's disease; diverticulitis; or other disorder of the stomach, intestines, liver or gallbladder?	☐ Yes ☐ No
g)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: Chronic Fatigue Syndrome, fibromyalgia, or Epstein-Barr Virus?	☐ Yes ☐ No
h)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: Oral Candidiasis (Thrush) or Lymphadenopathy (enlarged or swollen glands)?	☐ Yes ☐ No
i)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: sugar, albumin, blood or pus in urine, venereal disease, hepatitis, stone or other disorder of the kidney, bladder, prostate or reproductive organs?	☐ Yes ☐ No

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY SECTION - CONTINUED

(Coverage will not be considered unless ALL questions are answered. Does not apply to AHL minimedical® or Dental)

Please explain all "Yes" answers in the space provided below. In your explanations, identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of applicable physician(s) and/or hospital(s).

4. j)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: diabetes, thyroid or other endocrine disorders?	☐ Yes ☐ No
k)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including spine, back, neck or joints?	☐ Yes ☐ No
l)	Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, disorders of the skin, or lymph glands, cyst, tumor, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	☐ Yes ☐ No
m)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: allergies, anemia, sickle cell anemia or any other disorder of the blood?	☐ Yes ☐ No
n)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: a mental or nervous disorder to include depression, and/or anxiety, or a disorder of the central nervous system?	☐ Yes ☐ No
o)	Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: excessive use of alcohol, or any habit forming drug, or is currently taking any drug or drugs not prescribed by a physician?	☐ Yes ☐ No
5.	Has any person to be insured ever tested positive for exposure to the HIV virus or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No

6. For any person to be insured, list the name, address and phone number of their physicians, the date last seen, and the reason last seen. Also, if any person to be insured has had an examination, consultation or treatment by a member of the medical profession or been a patient in a hospital or other institution within the past 5 years, please provide details. Use the additional space provided at the bottom of this page if needed.

PERSON	REASON LAST SEEN Nature of any illness, injury, diagnosis, or wellness visit	DATES Including duration of illness	DEGREE OF RECOVERY	NAMES, ADDRESSES AND PHONE NUMBERS OF PHYSICIANS AND/OR HOSPITALS

7.	Has any person ever engaged in, or does he/she contemplate engaging in, underwater diving; piloting an airplane; parachuting; hang gliding; bungy jumping; rodeo; mountaineering; professional sports; auto, drag or motorcycle racing; or stunt driving? If "Yes," circle all that are applicable and explain the extent to which he/she is engaged in the activity: _____	☐ Yes ☐ No
8.	Has any person to be insured used tobacco in any form in the last 12 months? If "Yes," indicate type and date last used. Type used _____ Date last used (MM/DD/YR) _____	☐ Yes ☐ No

Use this space to explain any "Yes" answers to the questions in the evidence of insurability section. In your explanations identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of any applicable physician(s) and/or hospital(s). Use additional paper if needed.

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

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, the Medical Information Bureau 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 and MIB Notice. 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 enroll for it at a later date. Any such enrollment 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. No information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this coverage except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing prove positive.
IN/MIB (01/03)

MIB NOTICE
Information regarding your health will be treated as confidential. We may however, make a brief report to the Medical Information Bureau, a non-profit organization of life insurance companies, which operates an information exchange for 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 on its file. Upon receipt of a request from you, the Bureau arranges disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, PH. 617-426-3660. American Heritage Life Insurance Company or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits. However, no specific information pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will be disclosed to anyone outside the company or its employees, insurance affiliates, agents or reinsurers, except to a physician designated by the applicant, in writing, or in the absence of such designation, to the State Department of Health.

IN/MIB (03/02)