Allstate
Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive
Jacksonville, Florida 32224

PROOF OF GOOD HEALTH FOR VOLUNTARY LIFE AND/OR DISABILITY INSURANCE

HOME OFFICE USE ONLY
ACTION_____

To be completed by the employee:

EMPLOYER'S NAME	GROUP NUMBER	BRANCH NUMBER
EMPLOYEE'S NAME	OCCUPATION	
EMPLOYEE'S ADDRESS	SOCIAL SECURITY NUMBER	

Applying for: ☐ Life Insurance in the amount of: $_____ and/or ☐ Short Term - *or* - ☐ Long Term Monthly Disability Benefit of: $_____

COVERAGE WILL NOT BE CONSIDERED UNLESS *ALL* QUESTIONS ARE ANSWERED
USE A *SEPARATE FORM* FOR *EACH PERSON* FOR WHOM COVERAGE IS REQUESTED

1 ***Person for whom coverage requires proof of good health:*** *(Spouse or child over 18 must sign on back, in addition to the employee)*

a) Name	d) Height / Weight	f) Date of Birth
	_____feet _____inches _____lbs.	
b) Relation to Employee	e) Weight change in past year ☐ None Gain Loss Cause of Change	g) Place of Birth
c) Occupation	_____lbs._____lbs.	h) Sex

			Yes	No	
2	a	Why was coverage not requested when this person was first eligible?			DETAILS: Please explain all "yes" answers, except to question 3d. Identify the question number. Use space on the reverse side for any additional necessary explanation.
	b	Has this person been absent from work or unable to carry on normal activities due to illness or injury during the past 6 months?	☐	☐	
	c	Has this person had this coverage before?	☐	☐	
	d	Has this person ever been or is he/she now insured under any other policy issued by American Heritage Life? If so, give the Group No. or other Policy No.	☐	☐	
	e	Has this person ever been declined, postponed, canceled, or charged an extra rate for life, accident or health insurance or received such a policy of insurance other than exactly as applied for?	☐	☐	
	f	Has this person ever made claim for or received benefits, pension, or other payment because of an injury, sickness or disability?	☐	☐	
3	a	Has any physician or dentist advised or recommended surgical, medical, dental or orthodontic treatment for this person, that has not been done yet?	☐	☐	
	b	Does this person now have an appointment to visit a physician or dentist within the next 30 days?	☐	☐	
	c	If this person is female, has she been advised by a physician that she is now pregnant? Will she visit a physician within the next 14 days to determine if she is pregnant?	☐ ☐	☐ ☐	
	d	Give the name of this person's personal physician and his/her dentist; the Date last seen; and Reason.			
4		*Has this person ever been treated for, or has he/she or the employee been told by a member of the medical profession that this person has or had:*			For questions 4 and 5 circle the applicable items for which a "yes" answer is given. Include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.
	a	high blood pressure, stroke, rheumatic fever, heart murmur, heart attack, a heart condition, heart trouble or other disorder of the heart or blood vessels (including artery disease)?	☐	☐	
	b	bronchitis, pleurisy, asthma, emphysema, tuberculosis or other chronic respiratory disorder, or a tonsillectomy or adenoidectomy?	☐	☐	
	c	epilepsy, muscular dystrophy, polio, osteomyellitis, or multiple sclerosis?	☐	☐	
	d	Rocky Mountain Spotted, scarlet, typhoid or undulant fever; diphtheria, encephalitis, rabies, tetanus, Hansen's Disease, bubonic plague, sickle cell anemia, small pox, Addison's Disease, tularemia, or meningitis?	☐	☐	
	e	jaundice, ulcer, hernia, hemorrhoids, appendicitis, colitis, Crohn's disease, diverticulitis, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐	

MIB NOTICE

Information regarding your health will be treated as confidential. American Heritage Life Insurance Company may, however, make a brief report to the Medical Information Bureau, a non-profit membership 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 in its file. Upon receipt of a request from you, the Bureau arranges disclosure of any information it may have in your file. (Medical information is disclosed only to your attending physician.) 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. American Heritage Life Insurance Company or its reinsurers may also release information in its file to other life 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.

			Yes	No	
4	*Has this person ever been treated for, or has he/she or the employee been told by a member of the medical profession that this person has or had:*				For questions 4 and 5 circle the applicable items for which a "yes" answer is given. Include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.
	f	sugar, albumin, blood or pus in urine, venereal disease, hepatitis, stone or other disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐	
	g	diabetes, thyroid or other endocrine disorders?	☐	☐	
	h	neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, neck, or joints?	☐	☐	
	i	disorder of skin, or lymph glands, cyst, tumor, cancer or any malignancy which includes carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma, and malignant tumor?	☐	☐	
	j	allergies, anemia or other disorder of the blood?	☐	☐	
	k	a speech defect, mental, psychoneurotic, or personality disorder, or disorder of the central nervous system?	☐	☐	
	l	excessive use of alcohol, or any habit forming drug, or is currently taking any drug or drugs not prescribed by a physician?	☐	☐	
5	Has this person 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?		☐	☐	

6 Has this person had an examination, consultation or treatment by any physician or practitioner of healing or been a patient in a hospital or other institution within the past five (5) years?_____. If "yes," give details as follows:

REASON Include the nature of any illness, injury, or diagnosis	DATES Including duration of illness			DEGREE OF RECOVERY	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

7 Has this person ever engaged in or does he 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._____

8 Has this person used tobacco in any form in the last 12 months?____. If "yes," indicate the type and the date last used._____

_____

Use this space for any additional necessary explanation. Indicate the applicable question numbers.

CERTIFICATION AND MEDICAL AUTHORIZATION

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 and/or the Plan Administrator as an inducement to grant insurance and/or coverage under the Employer's self-insured benefit plan, and I understand that American Heritage Life Insurance Company and/or the Plan Administrator may use any material misstatements to contest the validity of any coverage provided on the basis of this proof of good health.

I AUTHORIZE any licensed physician, medical practitioner, hospital or other medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or information regarding me or my family or our health, to disclose to American Heritage Life Insurance Company any such information. A copy of this authorization shall be as valid as the original.

Employee's Signature_____

Signed at_____
(City and State)

Witness_____
(Adult Non-Relative)

Date Signed_____

Dependent's Signature_____
(Required for Spouse or Child over 18)

Signed at_____
(City and State)

Witness_____
(Adult Non-Relative)

Date Signed_____

EMPLOYEE: TEAR OFF AND KEEP THIS NOTICE FOR YOUR RECORDS.

IMPORTANT NOTICE: 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 reputation 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.

SEE MIB NOTICE ON REVERSE SIDE