



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

Allstate

Workplace Division

New Certificate
 Change/Increase Certificate # _____

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks

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	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)		RESIDENT PHONE NUMBER		EMPLOYER		DATE OF HIRE (MM/DD/YEAR)
HEIGHT	WEIGHT	JOB TITLE		PLANT OR DIVISION	REHIRE DATE (MM/DD/YEAR)	
EMPLOYEE'S EMAIL			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 Accident Yes No **Group Voluntary Hospital Indemnity** Yes No
Group Voluntary Cancer/Specified Disease Yes No **Heritage Choice Dental** 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?

Accident Yes No Cancer 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 _____

PLEASE COMPLETE FOR PERSONS TO BE INSURED

(Use additional paper if needed.)

Abbreviations: Acc-Accident Can-Cancer Hosp-Hospital Indemnity Den-Dental

Choose Plan(s):				Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number	Actively At Work*
Acc	Can	Hosp	Den						
					Employee				<input type="checkbox"/> Yes <input type="checkbox"/> No
					Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No
									N/A
									N/A
									N/A

*Actively at work means that he/she is actively at work now for wage or profit and has 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.

Premium/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other Date of Issue _____	Case Number	Agent Number	Percentage Credit
	Employee Number		
	Situs State		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units _____	<input type="checkbox"/> Benefit Enhancement Rider Units: _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Optional Disability Riders for Employee <input type="checkbox"/> Off the Job Accident <input type="checkbox"/> Off the Job Accident and Sickness <input type="checkbox"/> On and Off the Job Accident <input type="checkbox"/> On and Off the Job Accident and Sickness				Employee Monthly Salary \$ _____	Rider Units _____
Optional Disability Riders for Spouse <input type="checkbox"/> On and Off the Job Accident for Insured Spouse* <input type="checkbox"/> On and Off the Job Accident and Sickness for Insured Spouse* *Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.				Spouse Monthly Salary \$ _____	Rider Units _____
Strike/Layoff Riders: (Only one Rider may be selected.) <input type="checkbox"/> Continuation During Strike or Layoff Rider <input type="checkbox"/> Premium Refund Upon Layoff Rider (Not available on Section 125 plans)					

Cancer/Specified Disease <input type="checkbox"/> Yes <input type="checkbox"/> No (GVCP3)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____				
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Wellness Benefit Option <input type="checkbox"/>
Units				1			
Strike/Layoff Riders: (Only one Rider may be selected.) <input type="checkbox"/> Continuation During Strike or Layoff Rider <input type="checkbox"/> Premium Refund Upon Layoff Rider (Not available on Section 125 plans)							

Hospital Indemnity <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____			
Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option <input type="checkbox"/>	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
Units						1	
Strike/Layoff Riders: (Only one Rider may be selected.) <input type="checkbox"/> Continuation During Strike or Layoff Rider <input type="checkbox"/> Premium Refund Upon Layoff Rider (Not available on Section 125 plans)							

Heritage Choice Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+One <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Were you covered under your Employer's prior Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the date coverage effective _____				

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM
EVIDENCE OF INSURABILITY SECTION

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

If any of the questions 1-6 below are answered "yes", please list the required health history on the next page.		
Cancer, Hospital Indemnity & Sickness Disability Riders	1. 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), or ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickness Disability Riders	2a. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer & Hospital Indemnity	3a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	4. Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thalassemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intensive Care Option (Cancer Only) & Hospital Indemnity	5a. 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Indemnity	6. 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 multiple 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

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 1-6 on page 3. 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 provided 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 AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this 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, it's subsidiaries or its reinsurers any 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. 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)



Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).