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

Allstate. BENEFITS

Group Enrollment and Evidence of Insurability Form

☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
53850						TN

Deduction Mode: ☒ Weekly

Remarks	*AHL home office use only*	Dep Code ☐ E ☐ S ☐ C ☐ F

General Information

All references to spouse include civil union and domestic partner relationships.

Employee Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union Easley Transportation	Hire Date	Occupation*	

**Occupation with the employer in the General Information section.*

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Qualifying Life Event

Are you applying for coverage or changing existing coverage due to a qualifying event? ☐ Yes ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination
☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying event date _____ Current certificate number(s) _____

Termination of Current Coverage

Do you currently have any individual coverages with AHL that you wish to terminate in conjunction with this enrollment for group coverage? ☐ Yes ☐ No

If yes, enter the following information: Effective date of termination _____ Policy Number _____

Select the type of coverage: ☐ Disability ☐ Indemnity Medical

Employee Name _____ Account No. 53850

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

Disability (GVDIP Short-Term) My Lifeline

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Provide: Monthly Earnings* $ _____ Monthly Benefit $ _____

**Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.*

Elimination and benefit period:

Elimination Period: 14 Days Accident 14 Days Sickness Benefit Period: 3 Months

Total Deduction

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No If yes, provide the company name:

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, provide the following: Company Name Year Issued

Monthly Benefit $ Elimination Period Benefit Period

Indemnity Medical II (GIM2) New Generation

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Choose One: ☐ Plan 1 ☐ Plan 2

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Home office use only

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Employee Name _____ Account No. 53850

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Eligibility Question

Answer each question for the coverages for which you are applying.

Employee answer for the following: Disability

Employee Actively At Work. Is the employee 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 the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? **Employee** ☐ Yes ☐ No

Underwriting Questions

Answer each question for the coverages for which you are applying. If any of the questions below are answered yes, list the required health history at the end of the section.

Answer for the following: Disability

1. **AIDS History.** In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for Acquired Immune Deficiency Syndrome (AIDS), or has the person(s) to be insured tested positive for antigens or antibodies to an AIDS virus? **Employee** ☐ Yes ☐ No

Answer for the following: Disability

2. **Blood Pressure History.** In the last year, has the person(s) to be insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once that was confirmed by a member of the medical profession? **Employee** ☐ Yes ☐ No

Answer for the following: Disability

3. **Major Medical Condition History.** In the last 2 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following? **Employee** ☐ Yes ☐ No
   - Cancer (except basal cell carcinoma)
   - Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)
   - Chronic Fatigue Syndrome
   - Counseling for alcohol or drug abuse
   - Diabetes
   - Emphysema
   - Fibromyalgia
   - Heart Disease/Disorder
   - Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
   - Liver Disease/Disorder
   - Lung Disease/Disorder
   - Lupus
   - Optic Neuritis
   - Pancreas Disease
   - Parkinson's Disease
   - Paralysis
   - Rheumatoid Arthritis
   - Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation

Answer for the following: Disability

4. **Back/Asthma History.** In the last 2 years, has the person(s) to be insured had any disease of, been impaired by, or received treatment from a member of the medical profession for, the following (other than minor illness)? **Employee** ☐ Yes ☐ No
   - Any disorder of the back or neck
   - Asthma

Answer for the following: Disability

5. **Advised Medical Procedure History.** In the last 5 years, has a member of the medical profession advised or recommended that the person(s) to be insured have any medical or surgical procedures (including organ transplant), which have not yet been performed? **Employee** ☐ Yes ☐ No

Answer for the following: Disability

6. **Pregnant/Fertility Treatment.** Is the person(s) to be insured currently pregnant or undergoing fertility treatment? **Employee** ☐ Yes ☐ No

Provide height and weight.

7. **Employee for the following:** Disability **Height:** _____ ft. _____ in **Weight:** _____ lbs.

Employee Name _____ Account No. 53850

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Answer for the following: All products

8. **Required Health History.** 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:

REPRESENTATION. I have read or had read to me this completed form and understand that any misstatement or misrepresentation in this form may result in loss of coverage. I represent that statements and answers given on this form are true, complete, and correctly recorded. UNDERSTANDING. I understand that: if premiums for the coverage(s) is (are) to be paid 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, AHL will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. 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 form may be declined on the basis of such proof. PREMIUM DEDUCTION AUTHORIZATION (EMPLOYEE). I AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Employee Signature _____ City/State _____ Date Signed _____

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer					

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 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).

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