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

Allstate. BENEFITS

Group Enrollment and Evidence of Insurability Form

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

Deduction Mode *(choose one)*: ☐ Monthly ☐ Semi-Monthly ☐ Weekly ☐ Bi-Weekly ☐ Other _____

Remarks	*AHL home office use only*

General Information

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

Employee (Payor/Owner/Certificate holder) 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	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.

Tobacco Use

If applying for Life or Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Life or Critical Illness, has the employee's spouse used tobacco in the last 12 months? **Spouse** ☐ Yes ☐ No

If applying for Life coverage for a dependent child (age 19 or older) as the proposed insured, has that dependent child used tobacco in the last 12 months? **Child** ☐ Yes ☐ 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: ☐ Accident ☐ Cancer ☐ Critical Illness ☐ Disability ☐ Hospital Indemnity

Employee Name _____ Account No. _____

Group Enrollment and Evidence of Insurability Form

Selection of Coverage

Answer yes or no and complete for each coverage selected.

Accident (GVAP1 On and Off the Job Accident)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:	Units
Base Coverage	
☐ Employee Off-the-Job Accident Disability Rider	
☐ Employee On and Off-the-Job Accident Disability Rider	
☐ Employee Off-the-Job Accident/Sickness Disability Rider	
☐ Employee On and Off-the-Job Accident/Sickness Disability Rider	
☐ Spouse On and Off-the-Job Accident Disability Rider*	
☐ Spouse On and Off-the-Job Accident/Sickness Disability Rider*	
☐ Benefit Enhancement Rider	

*****Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 20 hours per week for 3 or more consecutive months.*

Provide for disability riders:

Employee Monthly Earnings $ _____

Spouse Monthly Earnings $ _____

Accident (GVAP2 Off the Job Accident)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:	Units
Base Coverage	
☐ Benefit Enhancement Option	
☐ Outpatient Physician's Rider	

Accident (GVAP6)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:	Units
Base Coverage	
☐ Accident Treatment & Urgent Care Rider	
☐ Emergency Room Services Rider	
☐ Outpatient Physician's Rider	
☐ Dislocation/Fracture Rider	
☐ Benefit Enhancement Rider	
☐ Accidental Death, Dismemberment & Functional Loss Rider	

Employee Name _____ Account No. _____

Group Enrollment and Evidence of Insurability Form

Cancer/Specified Disease (GVCP2)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Family

Plan _____

Total Deduction

Choose coverage:	Units
Hospital	
Radiation/Chemotherapy	
Surgery Related	
Miscellaneous	1
☐ Cancer Initial Diagnosis Option	
☐ Cancer Screening Option	

Cancer/Specified Disease (GVCP3)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:	Units
Hospital	
Radiation/Chemotherapy	
Surgery Related	
Miscellaneous	1
☐ Cancer Initial Diagnosis Option	
☐ Intensive Care Option	
☐ Wellness Option	
☐ Cancer Progressive Benefit Option	

Critical Illness (GVCIP1) My Lifeline

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:

- ☐ Critical Illness Cancer Option
- ☐ Recurrence Option
- ☐ Wellness Option Units _____
- ☐ Second Evaluation Benefit Rider

Basic Benefit Amount*: $ _____

**If covered, basic benefit amount for spouse and other dependents is 50% of employee benefit.*

Critical Illness (GVCIP2)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:

- ☐ Cancer Critical Illness Option
- ☐ Second Event Initial Critical Illness Option
- ☐ Wellness Option Units _____
- ☐ Second Event Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Option I (HIV)
- ☐ Supplemental Critical Illness Option II
- ☐ Second Evaluation Benefit Rider

Basic Benefit Amount: $ _____

Employee Name _____ Account No. _____

Group Enrollment and Evidence of Insurability Form

Critical Illness (GVCIP4) My Lifeline

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Choose coverage:

Basic Benefit Amount: $ _____

- ☐ Cancer Critical Illness Option
- ☐ Reoccurrence of Critical Illness Option
- ☐ Second Evaluation, Transportation & Lodging Rider
- ☐ Reoccurrence of Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Rider with HIV
- ☐ Supplemental Critical Illness Rider without HIV
- ☐ Wellness Rider - Fixed Units _____
- ☐ Wellness Rider - Variable Units _____
- ☐ Skin Cancer Rider
- ☐ Cardiopulmonary Enhancement Rider
- ☐ Specified Chronic Illness Rider
- ☐ Specified Chronic Illness or Injury Rider
- ☐ Lifestyle Enhancement Rider

Disability (GVDIP Short-Term) My Lifeline

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Provide: Monthly Earnings* $ _____ Monthly Benefit $ _____

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

Choose elimination and benefit periods:

Elimination Period: _____ Days Accident _____ Days Sickness Benefit Period: _____ 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

Hospital Indemnity (GVSP1)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage: Units

- Hospital Related _____
- Surgery/Inpatient Physician _____
- Outpatient Related _____
- ☐ Diagnostic/Wellness Option _____
- ☐ Prescription Drug Option _____
- ☐ Disability Rider _____
- ☐ Life Rider _____

Employee Name _____ Account No. _____

Group Enrollment and Evidence of Insurability Form

Life Do you want this coverage? ☐ Yes ☐ No ☐ *Guaranteed Issue* ☐ *Contingent Guaranteed Issue* ☐ *Simplified Issue*

Life product being offered: ☐ Universal Life (UL) ☐ Term Life ☐ Whole Life

Choose one (UL only): Death Benefit Option ☐ 1 ☐ 2

Requested Face Amount $ _____

Employee Annual Base Salary $ _____

Total Deduction

Riders being applied for:	Units/Amt.

If the proposed insured is your spouse, child or grandchild, provide the following for that proposed insured. ☐ Spouse ☐ Child ☐ Grandchild

Proposed Insured Name *(Last, First, M.I.)*		Social Security No.	☐ Male ☐ Female
Residence Street Address		Birth Date	
City, State, Zip	Phone No.	Email Address	
Employer of Proposed Insured	Annual Salary	Occupation	

Is the child or grandchild proposed for coverage a full-time student? ☐ Yes ☐ No

If the answer is no and the child or grandchild is 19 or older, is he/she 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? ☐ Yes ☐ No

If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Replacement and Existing Insurance *(Must answer)*

1a. Replacement. Proposed Insured. Is this insurance to replace or change any existing life coverage? ☐ Yes ☐ No

If yes, indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state.

1b. Producer. To your knowledge, is change or replacement involved? ☐ Yes ☐ No

2a. Existing Insurance. Proposed Insured. Is there any other (not listed in Question 1a.) life insurance in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. ☐ Yes ☐ No

2b. Producer. To your knowledge, does the proposed insured have existing coverage in force? ☐ Yes ☐ No

Group Enrollment and Evidence of Insurability Form

Accelerated Death Benefit for Long Term Care Rider *(Must answer)*

1. Secondary Addressee Designation. Protection against unintended lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. Would you like to designate at least one additional person to receive notification of a possible lapse or termination of coverage? If yes, please provide full name and mailing address. ☐ Yes ☐ No

Name *(Last, First, M.I.)*	
Residence Street Address	City, State, Zip

2. Replacement. Is this rider to replace or change any existing accident and health or long term care coverage? If yes, please indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state. ☐ Yes ☐ No

3a. Existing Insurance. Is there any other long term care insurance in force (including health care service contract or health maintenance organization contract) on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. ☐ Yes ☐ No

3b. Has there been any other long term care insurance in force during the last 12 months on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. If that insurance lapsed, state when it lapsed. ☐ Yes ☐ No

3c. Are you covered by TennCare? ☐ Yes ☐ No

4a. Producer. List all accident and health or sickness insurance policies which you have sold the applicant.

4b. Producer. List all accident and health or sickness insurance policies you sold to this applicant which are still in force.

4c. Producer. List all accident and health or sickness insurance policies you sold to this applicant in the past five years that are no longer in force.

Illustration Regulation Certification for Universal Life and Term Life

OWNER. The owner must select one of the following statements.

☐ I certify that I have received an illustration conforming to the coverage applied for. I will complete the applicable illustration certification form provided, if required in my state.

☐ I certify that I did not receive an illustration conforming to the coverage applied for. I understand that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

PRODUCER. The producer must select one of the following statements.

☐ I certify that an illustration conforming to the coverage applied for was provided. I will complete the applicable illustration certification form provided, if required.

☐ I certify that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

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.	

Employee Name _____ Account No. _____

Group Enrollment and Evidence of Insurability Form

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

Eligibility Questions

GI -- Guaranteed Issue
CGI -- Contingent Guaranteed Issue
SI -- Simplified Issue

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

Employee answer for the following: Accident w/Sickness Disability Rider, Cancer, Critical Illness, Disability, Hospital Indemnity, GI Life, CGI Life, SI Life

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

Spouse answer for the following: Accident w/Sickness Disability Rider, CGI Life, SI Life

Spouse Actively At Work. Is the employee's spouse 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?

Spouse ☐ 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. *For Critical Illness, underwriting questions are not applicable to children.*

Answer for the following: Accident w/Sickness Disability Rider, Cancer, Critical Illness*, Disability, Hospital Indemnity, CGI Life, SI Life

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
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: CGI Life, SI Life

2. **Recently Disabled/Hospitalized.** In the last 6 months, has the person(s) to be insured been disabled or hospitalized for anything other than lacerations or broken bones due to an accident, or normal pregnancy?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: SI Life

3. **Chronic Disease 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
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

- Anemia (other than iron deficiency)
- Anxiety, depression or other mental or nervous illness (that resulted in hospitalizations, disability from work, or suicide attempts)
- Asthma (only if taking steroidal medication and/or have been hospitalized)
- Cancer, except basal cell carcinoma
- Diabetes
- Epilepsy and/or seizure disorder
- Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder
- Hemophilia
- Hepatitis
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lou Gehrig's Disease (ALS)
- Lung Disease/Disorder (other than asthma)
- Lupus
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation
- Transplant of any organ
- Counseling for, or excessive use of, alcohol or any type of drugs

Employee Name _____ Account No. _____

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Answer for the following: Accident w/Sickness Disability Rider, Cancer w/Intensive Care Option, Critical Illness*, Disability, Hospital Indemnity, SI Life

4. **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
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: SI Life

5. **Driving History.** In the last 3 years, has the person(s) to be insured had his/her driver's license suspended or revoked due to driving violations, been convicted of reckless driving or driving under the influence, been involved in 3 or more motor vehicle accidents, or received 3 or more moving violations? If yes, provide details including license number and state of issue.

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Cancer, Critical Illness Cancer Option*, Hospital Indemnity

6a. **Cancer Diagnosis/Treatment History.** Has a member of the medical profession ever diagnosed or treated the person(s) to be insured for any type of cancer (except basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

6b. **Cancer Leukemia/Lymphoma.** If the answer to the Cancer Diagnosis/Treatment History question is yes, has a member of the medical profession diagnosed or treated that person(s) for Leukemia, Hodgkin's Disease, Lymphoma, or cancer with any lymph node involvement or metastasis?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

6c. **Cancer Other.** If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a member of the medical profession diagnosed or treated that person(s) for any other type of cancer (other than those listed in the Cancer Leukemia/Lymphoma question and/or basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Accident w/Sickness Disability Rider, Critical Illness, Disability

7. **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
Spouse ☐ 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: Accident w/Sickness Disability Rider, Disability

8. **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
Spouse ☐ Yes ☐ No

- Any disorder of the back or neck
- Asthma

Answer for the following: Cancer w/Intensive Care Option, Hospital Indemnity

9. **Heart/Stroke History.** In the last 5 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
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

- Any artery disease
- Any abnormality of the heart
- Heart attack
- Heart condition
- Heart trouble
- Stroke or transient ischemic attack (TIA)

Employee Name _____ Account No. _____

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Answer for the following: Accident w/Sickness Disability Rider, Critical Illness*, Disability, Hospital Indemnity, SI Life

10. **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
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Specified Chronic Illness Rider, Supplemental Critical Illness Benefits Option/Rider

11. **Brain/Eye/Hearing Disorder History.** In the last 5 years, has a member of the medical profession diagnosed, advised, treated, or consulted the person(s) to be insured 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

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

Answer for the following: Specified Chronic Illness Rider

12. **Specified Disease Critical Illness 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?
    - Addison's Disease
    - Benign Brain Tumor
    - Huntington's Disease
    - Osteomyelitis
    - Osteoporosis
    - Lou Gehrig's Disease (ALS)

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

Answer for the following: Cancer

13. **Specified Disease History.** Has a member of the medical profession ever diagnosed or treated the person(s) to be insured for any of the following?
    - Addison's Disease
    - Brucellosis
    - Cerebrospinal meningitis
    - Cystic Fibrosis
    - Encephalitis
    - Hansen's Disease
    - Hepatitis (Chronic B, Chronic C with liver failure, or hepatoma)
    - Legionnaires' 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
    - Thalassemia
    - Tuberculosis
    - Tularemia
    - Typhoid Fever

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Disability, Hospital Indemnity

14. **Pregnant/Fertility Treatment.** Is the person(s) to be insured currently pregnant or undergoing fertility treatment?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Provide height and weight.

15. **Employee for the following:** SI Life, Critical Illness, Disability, Hospital Indemnity — Height: _____ ft. _____ in Weight: _____ lbs.

Spouse for the following: SI Life (when proposed insured) — Height: _____ ft. _____ in Weight: _____ lbs.

Child for the following: SI Life (when proposed insured) — Height: _____ ft. _____ in Weight: _____ lbs.

Answer for the following: Critical Illness* (over $50,000), SI Life (over $150,000)

16. **Physician Information.** Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured. The required health history section may be used if additional space is needed.

Employee Name _____ Account No. _____

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Answer for the following: All products

17. **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. AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS). I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, 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. This authorization applies to any minor dependent for 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.

Caution: If your answers on this application are incorrect or untrue, AHL has the right to deny benefits or rescind your Accelerated Death Benefit for Long Term Care coverage, if applied for.

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/Payor/Owner Signature | City/State | Date Signed

Proposed Insured Signature (if not employee/payor/owner and if required by your state or face amount being requested)

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.

Soliciting Producer Signature | Soliciting Producer Name Printed

Home office or producer to complete before issue:

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

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. You may request to be interviewed in connection with the report and may also receive a copy of the report upon request. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. 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.

IN/MIB-4 (2020)

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901, www.mib.com. American Heritage Life 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.

IN/MIB-4 (2020)

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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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.
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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.
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