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

Allstate. BENEFITS

whole life

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, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Life, 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) _____

Employee Name _____ Account No. _____

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

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

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

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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

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.	

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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: 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: 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.

Answer for the following: 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

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Answer for the following: 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: SI Life

6. 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

Provide height and weight.

7. Employee for the following: SI Life — **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: SI Life (over $150,000)

8. 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.

Answer for the following: All products

9. 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).** 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

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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		