AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

Group Universal LIfe

☐ New Certificate
☐ Change Certificate _____
☐ Reinstatement _____

Please print with black ink

EMPLOYEE/MEMBER INFORMATION SECTION

(Please complete entire section)

EMPLOYEE/MEMBER NAME Last First M.I.	☐ M ☐ F	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YYYY)	☐ Married ☐ Single
RESIDENCE ADDRESS	CITY	STATE	ZIP	
EMPLOYER/ASSOCIATION/UNION	DATE HIRED (MM/DD/YEAR)	PHONE NUMBER		
EMPLOYEE'S EMAIL / OCCUPATION	PLANT OR DIVISION	ANNUAL SALARY $		

Are you actively at work now and have you worked at least 20 hours each week performing all your duties at your regular occupation at your regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ☐ Yes ☐ No
If not, why? _____

PROPOSED INSURED'S INFORMATION SECTION

(Please complete entire section unless employee/member is proposed insured; then complete information not provided above)

NAME (Last, First, M.I.)	☐ Emp./Mem. ☐ Spouse ☐ Child ☐ Other	☐ M ☐ F	AGE	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YYYY)
RESIDENCE ADDRESS	CITY	STATE	ZIP		
OCCUPATION	EMPLOYER	ANNUAL SALARY $	PHONE NUMBER		
OWNER'S NAME AND RESIDENCE ADDRESS	CITY	STATE	ZIP		
PRIMARY BENEFICIARY FULL NAME AGE RELATIONSHIP	CONTINGENT BENEFICIARY FULL NAME AGE RELATIONSHIP				

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?
☐ Yes ☐ No
If "Yes", indicate type of change: _____
Date of change _____ Current Certificate Number _____

DEPENDENT COVERAGE SECTION

(Please complete if children's term and/or other insured's term rider coverage elected. Use additional paper if needed.)

Dependent's Name(s) (Last, First, M.I.)	**Relationship**	**Sex**	**Date of Birth** (MM/DD/YEAR)

SELECTION OF COVERAGE SECTION

☐ SI ☐ CGI ☐ GI (Employee only) **Universal Life** _____	Death Benefit Option ☐ 1 ☐ 2	Face Amount $	Mode Premium $

Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt									

Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No
If so, who? _____

Remarks

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other Date of First Deduction _____ Requested Issue Date _____	Case Number	Producer/ Agent Number	Percentage Credit
	Employee/Member ID		
	Situs State		

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY SECTION

(If question 1 is answered "No" or questions 2-6 are answered "Yes", please list the requested information in 8 below.)

Eligibility - Spouse Only	
1. Is the person to be insured actively at work now and has he/she 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?	☐ Yes ☐ No
Contingent Guaranteed Issue (Must answer questions 2, 3, 9 and 10)	
2. 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?	☐ Yes ☐ No
3. Has any person to be insured been disabled or hospitalized in the last 6 months?	☐ Yes ☐ No
Simplified Issue (Must answer questions 2-10)	
4a. In the last 3 years, has any person to be insured: had a chronic disease (including but not limited to heart disorder, stroke, cancer, diabetes, etc.); been hospitalized; seen a physician (other than for colds, flu or normal pregnancy or a routine physical with no unfavorable results); or been counseled for or excessively used alcohol or any type of drugs?	☐ Yes ☐ No
b. Is any person to be insured currently under the care or treatment of a physician (including but not limited to currently using prescription medications for injury or illness)?	☐ Yes ☐ No
5a. Has any person to be insured ever been diagnosed with hypertension or high blood pressure?	☐ Yes ☐ No
b. If the answer to 5a is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
6. Please provide person to be insured's height and weight: Height: Weight:	
7. Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details. _____	☐ Yes ☐ No

8.

Name	Nature of Illness/Injury or Medical Attention/ Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic

Replacement and Existing Insurance Section (Must Answer)	
9. **Replacement.** Is this insurance to replace or change any existing life coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state. _____ _____	☐ Yes ☐ No
10. **Existing Insurance.** Is there any other life insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. _____ _____	☐ Yes ☐ No

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

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 (Please read, sign and date)

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 as an inducement to grant insurance, and I understand that American Heritage Life Insurance Company may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Enrollment and Evidence of Insurability Form. **FRAUD WARNING:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. • **I UNDERSTAND** that the insurance being applied for will be effective as of the enrollment form date, provided the person(s) to be insured is (are) found acceptable for such insurance as applied for. • **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 Insurance Company, its subsidiaries or its reinsurers, any information. This information will be used by the Underwriting Department to determine eligibility for insurance. 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 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 Insurance Company in writing of my desire to do so. I or my representative may request a copy of this authorization. • **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage(s) requested above. 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.

Signed at: City/State: _____ Date Signed: _____

Signature of Proposed Insured: _____

Signature of Owner or Payor, if other than Insured: _____

Producer's Statement. **(Must complete)**

1. To your knowledge, is change or replacement involved? ☐ Yes ☐ No
2. To your knowledge, does the proposed insured have existing coverage in force? ☐ Yes ☐ No
3. I certify that to the best of my knowledge and belief the information on this enrollment form is complete, accurate and correctly recorded.

Signature of Producer: _____ Print Producer's Name: _____

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. The purpose of this information is to determine your eligibility for insurance. This inquiry includes information as to your character, general information and personal characteristics. You may request to be interviewed in connection with the preparation of the investigative report and 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. You or your representative are entitled to receive a copy of this investigative consumer report upon your request. No information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this coverage except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing prove positive.

GIN/MIBVA **(09/08)**

MIB NOTICE:

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (Bureau), a non-profit 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. 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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH.# 866-692-6901 (TTY 866-346-3642 for hearing impaired). American Heritage Life Insurance Company 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. 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.

GIN/MIBVA **(09/08)**