COMPLETE THIS FORM IF YOU ARE ELECTING OR CHANGING CANCER & SERIOUS DISEASE

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only
ANNUAL ENROLMENT	

GENERAL INFORMATION

Employee's Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number		
Residence Address	City	State	Zip	
Date of Birth / Phone Number	Email			
Employer/Association/Union: **General Health Systems** / Date Hired	Occupation	Plant Or Division: N/A		
Primary Beneficiary's Full Name and Address / City / State / Zip	Relationship			
Phone Number / Date of Birth	Social Security Number			
Contingent Beneficiary's Full Name and Address / City / State / Zip	Relationship			
Phone Number / Date of Birth	Social Security Number			

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number
		Employee			
		Spouse			

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

If "Yes", check the qualifying event: ANNUAL ENROLLMENT

☐ Marriage	☐ Spouse/Dependent Child Death	☐ Newly Eligible
☐ Divorce	☐ Eligible/Ineligible Child	☐ Termination
☐ Birth/Adoption	☐ Spouse New Job/Job Loss	☐ Employee Death

Date of Qualifying Event _____ Current Certificate Number(s) _____

Do you currently have the following Individual coverage with American Heritage Life Insurance Company (AHL)?
Cancer ☐ Yes ☐ No
If you answered "Yes" to the coverage, please enter the Policy Number _____
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

Premium/Billing Mode ☒ Bi-weekly Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	93339		**LA**

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE

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

Cancer/Specified Disease (GVCP2) ☒ Yes ☐ No	Plan 2	**Total Bi-weekly Premiums** Employee Only ☐ $ 7.08 Family ☐ $11.84	Section 125 ☒ Yes ☐ No	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☒ Cancer Initial Diagnosis Option	☒ Cancer Screening Option
Units	2	3	2	1	2	2

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

	Eligibility Question	**EE**	**SP**	**CH**
Cancer	**1.** 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?	☐Y ☐N	N/A	N/A
If any of the questions below are answered "yes", please list the required health history on page 2.				
	Underwriting Questions	**EE**	**SP**	**CH**
Cancer	**2.** Has any person to be insured, in the last 5 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer & Cancer Initial Diagnosis Option	**3a.** Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	3b. If the answer to 3a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	3c. If the answer to 3a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 3b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer	**4.** Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any of the following?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	• Addison's Disease • Brucellosis • Cerebrospinal meningitis • Cystic Fibrosis • Encephalitis • Hansen's Disease • Hepatitis (Chronic B or 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 • Tuberculosis • Thalassemia • Tularemia • Typhoid Fever			
Required Health History	**5.** 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 the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application 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, American Heritage Life 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 application may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.

FRAUD NOTICE: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

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.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer:			%
Soliciting Producer:			%
			%
			%
			%

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ELECTRONIC DELIVERY ELECTION (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance (certificate(s)) and/or my policy(ies), including all documents accompanying my certificate(s) and/or my policies. I also elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) and/or my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will be mailed instructions at the last provided residence address and/or email address on how to receive my certificate(s), policy(ies) and correspondence at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 9.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. 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(s) and/or my policy(ies), 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.

I understand and agree that this election is effective for all certificate(s) and/or policy(ies) applied for and/or enrolled in on the date signed as noted below.

Proposed Insured Name: _____ Date Signed: _____

Owner Printed Name (if other than Insured): _____ Account Number (if applicable): _____

Owner Social Security Number: _____ Account Name (if applicable): _____

Owner Signature: _____

**Completed forms must be returned to the Benefits Department by November 18,2016

or coverage will not be extended. Please use postage-paid envelope provided**

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 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 (SHIIP).

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