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
23356						IN

Deduction Mode: ☒ Bi-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 Heavy Duty Trucking	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 Critical Illness, has the employee used tobacco in the last 12 months? Employee ☐ Yes ☐ No

If applying for Critical Illness, has the employee's spouse used tobacco in the last 12 months? Spouse ☐ 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 ☐ Critical Illness

Employee Name _____ Account No. 23356

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

Accident (GVAP2 Off the Job Accident)

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

Choose coverage amount:

Total Bi-weekly Deductions	Plan 1	Plan 2
Employee Only	☐ $ 5.84	☐ $ 7.84
Employee + Spouse	☐ $ 8.46	☐ $11.38
Employee + Child(ren)	☐ $11.82	☐ $15.88
Family	☐ $14.80	☐ $19.84

Your coverage will consist of:	Plan 1	Plan 2
Base Coverage	2	3
Benefit Enhancement Option	2	1
Outpatient Physician's Rider	3	4

Critical Illness (GVCIP2)

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

Your coverage will consist of:

Basic Benefit Amount: $ 10,000

- ☒ Cancer Critical Illness Option
- ☒ Second Event Initial Critical Illness Option
- ☒ Wellness Option Units 2
- ☒ Second Event Cancer Critical Illness Option
- ☒ Supplemental Critical Illness Option II

Bi-weekly Deductions	$10,000 Basic Benefit Non-Tobacco				$10,000 Basic Benefit Tobacco			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-29	☐ $ 2.46	☐ $ 3.98	☐ $ 2.46	☐ $ 3.98	☐ $ 3.60	☐ $ 5.68	☐ $ 3.60	☐ $ 5.68
30-39	☐ $ 4.30	☐ $ 6.74	☐ $ 4.30	☐ $ 6.74	☐ $ 6.66	☐ $10.26	☐ $ 6.66	☐ $10.26
40-49	☐ $ 7.78	☐ $11.96	☐ $ 7.78	☐ $11.96	☐ $13.72	☐ $20.86	☐ $13.72	☐ $20.86
50-59	☐ $13.64	☐ $20.74	☐ $13.64	☐ $20.74	☐ $22.96	☐ $34.72	☐ $22.96	☐ $34.72
60-63	☐ $22.00	☐ $33.28	☐ $22.00	☐ $33.28	☐ $37.64	☐ $56.76	☐ $37.64	☐ $56.76
64+	☐ $28.48	☐ $43.02	☐ $28.48	☐ $43.02	☐ $49.22	☐ $74.12	☐ $49.22	☐ $74.12

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. 23356

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Eligibility Question

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

Employee answer for the following: Critical Illness

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: Critical Illness

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

Answer for the following: Critical Illness

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
Spouse ☐ Yes ☐ No

Answer for the following: Critical Illness Cancer Option

3a. **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

3b. **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

3c. **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

Answer for the following: Critical Illness

4. **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: Critical Illness

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
Spouse ☐ Yes ☐ No

Employee Name _____ Account No. 23356

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Answer for the following: Supplemental Critical Illness Benefits Option

6. **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

Provide height and weight.

7. **Employee for the following:** Critical Illness

Height: _____ ft. _____ in Weight: _____ lbs.

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. AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR 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.

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					

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.

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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. 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-3 (2012)

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).