

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Check appropriate box(es)

- Group Voluntary Accident**
 Group Voluntary Hospital Indemnity
 Group Voluntary Cancer/Specified Disease
 Heritage Choice Dental (enrollment only)

For AHL Home Office use only

Notes

GENERAL INFORMATION SECTION

(Please complete entire section for all coverages)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc)	First	M.I.	SEX	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married	<input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)			CITY		STATE	ZIP
BIRTHDAY (MM/DD/YEAR)	PHONE NUMBER		EMPLOYER		DATE OF HIRE (MM/DD/YEAR)	
GROUP POLICY NAME (If different from the employer name)			HEIGHT	WEIGHT	CURRENT EARNINGS	
					\$ _____ (also check appropriate box) <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	
JOB TITLE		PLANT OR DIVISION				
BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP			

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?

- Group Voluntary Cancer/Specified Disease** Yes No **Heritage Choice Dental** Yes No
Group Voluntary Hospital Indemnity Yes No **Group Voluntary Accident** Yes No

If "Yes", please complete the following: Qualifying Event _____

Date of Qualifying Event _____ Current Certificate Number _____

Do you currently have any of the following individual products with AHL?

- Cancer Yes No Accident Yes No Hospital Indemnity Yes No

If you answered "Yes" to any of the products, please enter the Policy Number _____

Do you wish to terminate this coverage? Yes No If "Yes", please enter effective date of termination _____

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Abbreviations: Acc-Accident Can-Cancer Den-Dental Hosp-Hospital

Choose Plans:	Dependent's Name	Relationship	Sex	Date of Birth	Social Security Number
Acc Can Den Hosp	(Last, First, M.I.)			(MM/DD/YEAR)	

Premium/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other Date of First Deduction _____ Cash With Application _____	Case Number	Agent Number	Percentage Credit
	Employee Number		
	Situs State		

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SELECTION OF COVERAGE SECTION

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

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Optional Disability Riders for Employee <input type="checkbox"/> Off the Job Accident <input type="checkbox"/> Off the Job Accident and Sickness <input type="checkbox"/> On and Off the Job Accident <input type="checkbox"/> On and Off the Job Accident and Sickness				Disability Rider Units Employee _____ Spouse* _____
Optional Disability Riders for Spouse* <input type="checkbox"/> On and Off the Job Accident for Insured Spouse* <input type="checkbox"/> On and Off the Job Accident and Sickness for Insured Spouse*				
Available only when family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months. *Or Domestic Partner				

Cancer/Specified Disease <input type="checkbox"/> Yes <input type="checkbox"/> No		Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____		
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Cancer Screening Option <input type="checkbox"/>
Units				1			
Do you currently have comprehensive health benefits from either an insurance policy or an HMO plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have answered "No", you may not apply for Group Voluntary Cancer/Specified Disease Coverage.							

Hospital Indemnity <input type="checkbox"/> Yes <input type="checkbox"/> No		Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse* <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family *or Domestic Partner	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____		
Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
Units				1		1	
Do you currently have comprehensive health benefits from either an insurance policy or an HMO plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have answered "No", you may not apply for Group Hospital Indemnity Coverage.							

Heritage Choice Dental <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse* <input type="checkbox"/> Employee+Child <input type="checkbox"/> Family *or Domestic Partner	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Were you covered under your Employer's prior Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the date coverage effective _____				AHL Home Office Use Only P1NG1 P1NG2 P1NG3	

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected. Does not apply to Dental.)

Non-Medical Questionnaire		
All Coverages	1. Is any 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If any of the questions 2-8 below are answered "yes", please list the required health history on the next page.		
All Coverages	2. Is any person to be insured now being treated, or in the last 10 years been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accident	3. 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 on the next page.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Riders Only	4a. Has any person to be insured, within the last 2 years, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accident & Sickness Disability Riders	b. Has any person to be insured been diagnosed, within the last 2 years, with hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. If the answer to 4b is yes, in the last year has he/she had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Has any person to be insured, in the last 2 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	5. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or in the last 10 years been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intensive Care Optional Benefit (Cancer Only)	6a. Is any person to be insured now being treated for, or in the last 10 years been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last 2 years, been diagnosed with hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. If the answer to 6b is yes, in the last year has he/she had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Indemnity	7a. Is any person to be insured currently being treated for, or has any person in the last 10 years been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor; a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last 2 years, been diagnosed with hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. If the answer to 7b is yes, in the last year has he/she had either a: (1) systolic blood pressure reading higher than 150 more than once or (2) diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Indemnity	8. Has any person to be insured, within the last 3 years, been treated for, or been told by a member of the medical profession that he or she has: epilepsy; hepatitis; muscular dystrophy or muscular sclerosis or any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs; paralysis; been counseled for alcohol or drug abuse; or had any medical or surgical procedure recommended but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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REQUIRED HEALTH HISTORY

***Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

Use this space for any additional explanation of questions 2-8 on page 3. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

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 evidence of insurability. • I UNDERSTAND that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this Evidence of Insurability form is signed. • I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical facility or insurance company, that has records or knowledge of me or my health to give to American Heritage Life, its subsidiaries or its reinsurers any information. I acknowledge receipt of the Important Notice About Privacy. 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 in writing of my desire to do so. • I ALSO AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested above. This signature also verifies the accuracy of the information on this enrollment form. 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.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

IMPORTANT NOTICE ABOUT PRIVACY:

In processing your application, an investigative report may be made. Information obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. 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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