

# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

### Group Voluntary Critical Illness

This box for AHL Home Office use only

### GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.) First M.I.		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)		CITY		STATE
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION		DATE HIRED (MM/DD/YEAR)
OCCUPATION		PLANT OR DIVISION		
Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", indicate type of change: _____				
Date of change _____ Current Certificate Number _____				
1. Do you currently have an individual Critical Illness product with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please enter the Policy Number _____				
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter effective date of termination _____				
2. 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 Critical Illness Coverage.				

### DEPENDENT COVERAGE SECTION

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

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

### SELECTION OF COVERAGE SECTION

<b>Critical Illness</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> My Lifeline <input type="checkbox"/> New Generation	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	<b>Home Office Use Only</b> SET ID _____
<b>Basic Benefit Amount \$</b> _____			Wellness Benefit Units _____	Critical Illness Cancer Option <input type="checkbox"/>	Recurrence Option <input type="checkbox"/>	
If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.						
Has any person to be insured used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If so, who and what type? _____						

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

# EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

## EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected.)

<b>Non-Medical Questionnaire</b>					
1. Is the proposed 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				
<b>Level 1 - Evidence of Insurability</b> If any of the questions below are answered "yes", please list the required health history on the next page.					
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)? 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				
3a. Has any person to be insured in the last 2 years had, 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; any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs, pancreas or back (including neck); or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
b. Is any person to be insured now being treated for, or ever been treated for: a stroke or transient ischemic attack (TIA); a heart attack; a heart condition; heart trouble; any abnormality of the heart; or any artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
c. Has any person to be insured been diagnosed with hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
d. If the answer to 3c 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				
e. 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				
f. Has any person to be insured 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				
g. Has any person to be insured received any advice, treatment or consultation for Alzheimer's Disease, dementia, senility or organic brain syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Cancer: Evidence of Insurability, if Cancer Option selected</b>					
4. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer (except basal cell skin cancer) or any malignancy which includes: carcinoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Level 2 - Additional Evidence of Insurability, if required</b>					
5. Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Are any persons to be insured currently taking any prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
7. In the past 5 years has any person to be insured received medical advice, sought treatment or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this Evidence of Insurability form?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
8. Please indicate height and weight	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Employee</td> <td style="border: none;">Spouse</td> </tr> <tr> <td style="border: none;">Height:                      Weight:</td> <td style="border: none;">Height:                      Weight:</td> </tr> </table>	Employee	Spouse	Height:                      Weight:	Height:                      Weight:
Employee	Spouse				
Height:                      Weight:	Height:                      Weight:				
<b>Level 3 - Additional Evidence of Insurability, if required</b>					
9. Please indicate the names and addresses of all physicians for each person to be insured; use the space provided on page 3 for additional explanations.					

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

### REQUIRED HEALTH HISTORY

List physician's name, address and telephone number

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

**Use this space for any additional explanation of questions 2-9 on page 2. 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 Enrollment and Evidence of Insurability Form. · I **UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this Enrollment and Evidence of Insurability Form is signed. · 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, it's 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 Insurance Company 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 coverage(s) requested above. This signature also verifies the accuracy of the information on this Enrollment and Evidence of Insurability 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)

Dependent's Signature \_\_\_\_\_ Signed at \_\_\_\_\_ Date Signed \_\_\_\_\_  
(Required for Spouse or Child over 18) (City and State)

**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. 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.

**GCI-IN**