Allstate
Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

EVIDENCE OF INSURABILITY FORM FOR ENROLLMENT OF GROUP ACCIDENT INSURANCE AND/OR GROUP VOLUNTARY CANCER/SPECIFIED DISEASE INSURANCE

EMPLOYEE'S NAME Last (Sr, Jr, etc) First M. I.	SEX	SOCIAL SECURITY NUMBER — —	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)		CITY	STATE / ZIP
BIRTHDAY (MM/DD/YR)	PHONE NUMBER	EMPLOYER	DATE OF HIRE (MM/DD/YR)
JOB TITLE	HEIGHT	CURRENT EARNINGS $_____ ☐ Hourly ☐ Bi-weekly (26) ☐ Monthly ☐ Semi-monthly (24) ☐ Weekly ☐ Annually	
PLANT OR DIVISION	WEIGHT		

Do you currently have any Individual Cancer/Specified Disease or Individual Accident coverage with American Heritage Life Insurance Company? Yes ☐ No ☐
If Yes, please enter the Policy Number _____
Do you wish to terminate this coverage? Yes ☐ No ☐ If Yes, please enter effective date of termination _____

To your knowledge, is this a change to your existing Group Cancer/Specified Disease coverage with American Heritage Life Insurance Company? Yes ☐ No ☐ If Yes, please enter Certificate Number and Date of Qualifying Event:
Certificate Number _____ Date of Qualifying Event _____

Accident Insurance ☐ Yes ☐ No	Base Units _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Optional Disability Riders for Employee and Spouse
☐ Off the Job Accident
☐ On and Off the Job Accident
☐ Off the Job Accident and Sickness
☐ On and Off the Job Accident and Sickness
☐ On and Off the Job Accident for Insured Spouse*
☐ On and Off the Job Accident and Sickness for Insured Spouse*
***Available only when family coverage is selected**

Disability Rider Units
Employee _____
Spouse _____

Cancer / Specified Disease ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Benefits	Hospital	Radiation/ Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option ☐	Intensive Care Option ☐	Cancer Screening Option ☐
Units				1			

Premium/Billing Mode
☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly
☐ Weekly ☐ Other_____

Date of First Deduction_____
Cash With Application_____

Case Number	Agent Number	Percentage Credit
Employee Number		
Situs State		

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected)

Choose Plans: Accident	Cancer	**Dependents Name** (Last, First, M. I.)	**SEX**	**Date of Birth** (MM/DD/YR)	**Social Security Number**
		Spouse			— —
		Child			— —
		Child			— —
		Child			— —
		Child			— —

GVC-4502 (04/02)

MIB NOTICE

Information regarding your health will be treated as confidential. American Heritage Life Insurance Company may, however, make a brief report to the Medical Information Bureau, a non-profit membership 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. (Medical information is disclosed only to your attending physician.) 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. American Heritage Life Insurance Company or its reinsurers may also release information in its file to other life 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.

Please explain all "yes" answers. Identify the question number. Use space below for any additional necessary explanation.		
Accident	1. Has any person proposed for coverage engaged in, or is any person contemplated engaging in: skydiving; hang gliding; underwater diving; organized racing events; rodeo; mountaineering; professional sports; or piloting a plane? If yes, circle the sport and furnish details.	Yes☐ No☐
Accident	2. Has any person proposed for coverage, in the last 3 years, had his/her drivers license suspended or revoked or been arrested for reckless or drunken driving and/or received 3 or more moving violations or been involved in 3 or more motor vehicle accidents? If yes, provide that persons drivers license information here and additional details below: Drivers License Number: _____ State:_____	Yes☐ No☐
Accident & Sickness Rider	3. Has any person proposed for coverage, within the last 2 years, had, been treated for, or been told by a member of the medical profession that he or 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); rheumatoid arthritis; any disorder of the heart, kidneys, liver, lungs or back; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or uncontrolled high blood pressure, or stroke?	Yes☐ No☐
Accident & Sickness Rider	4. Within the last 3 years, has any person proposed for coverage been medically treated for or been medically advised to have treatment for alcohol or drug use or dependency?	Yes☐ No☐
Accident & Sickness Rider	5. Has any person proposed for coverage had any medical or surgical procedures advised or recommended by a doctor but not done at this time?	Yes☐ No☐
Cancer / Accident	6. Has any person proposed for coverage been absent from work or unable to carry on normal activities due to illness or injury during the past 6 months?	Yes☐ No☐
Cancer / Accident	7. Is the proposed insured actively at work now and has he/she worked at least 25 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☐
Cancer / Accident	8. Is any person proposed for coverage currently being treated for, or ever been treated for, 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☐
Cancer	9. Is any person proposed for coverage currently being treated for, or ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	Yes☐ No☐
Cancer	10. Is any person proposed for coverage currently being treated for or ever been treated for: high blood pressure not controlled with medication; a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes?	Yes☐ No☐
Cancer	**Question 11 is for Cancer/Specified Disease. Include diagnosis, dates, duration, along with names and addresses of all attending physicians and medical facilities.**	

11. *Has any person proposed for coverage ever been treated for, or has a member of the medical profession told them they have or had:*

☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease); or ☐ Muscular Dystrophy; or ☐ Poliomyelitis; or ☐ Multiple Sclerosis; or ☐ Encephalitis; or ☐ Rabies; or ☐ Tetanus; or ☐ Tuberculosis; or ☐ Osteomyelitis; or ☐ Diphtheria; or ☐ Scarlet Fever; or ☐ Cerebrospinal Meningitis (bacterial); or ☐ Brucellosis; or ☐ Sickle Cell Anemia; or ☐ Thalassemia; or ☐ Rocky Mountain Spotted Fever; or ☐ Legionnaire's Disease; or ☐ Addison's Disease; or ☐ Hansen's Disease; or ☐ Tularemia; or ☐ Hepatitis (Chronic B or Chronic C with liver failure or hepatoma); or ☐ Typhoid Fever; or ☐ Myasthenia Gravis; or ☐ Reye's Syndrome; or ☐ Primary Sclerosing Cholangitis (Walter Payton's Liver Disease); or ☐ Lyme Disease; or ☐ Systemic Lupus Erythematosus; or ☐ Cystic Fibrosis; or ☐ Primary Biliary Cirrhosis?

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 necessary explanation of questions 1-10. Indicate the applicable question numbers.

CERTIFICATION AND MEDICAL AUTHORIZATION

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 any material misstatements 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 Specifications page, not the date this Evidence of Insurability form is signed.

I AUTHORIZE any licensed physician, medical practitioner, hospital or other medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or information regarding me or any family members proposed for this insurance or their health, to disclose to American Heritage Life Insurance Company any such information. A copy of this authorization shall be as valid as the original.

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: _____

GVC-4502 (04/02) (City and State)

EMPLOYEE: TEAR OFF AND KEEP THIS NOTICE FOR YOUR RECORDS.

IMPORTANT NOTICE: 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 reputation 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.

SEE MIB NOTICE ON REVERSE SIDE