Allstate.

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

GROUP VOLUNTARY CANCER/SPECIFIED DISEASE EVIDENCE OF INSURABILITY FORM

GENERAL INFORMATION SECTION

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc) First M.I.		SEX	SOCIAL SECURITY NUMBER
HOME ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDAY (MM/DD/YEAR)	EMPLOYER NC FLEX	DATE OF HIRE (MM/DD/YEAR)	REQUESTED ISSUE DATE (MM/DD/YEAR)
CASE NUMBER 83126	PLAN OPTIONS (choose one) ☐ Low Option ☐ High Option	COVERAGE LEVELS (choose one) ☐ Employee only ☐ Employee and Family	

Do you currently have an individual cancer product with AHL? ☐ Yes ☐ No

If you answered "Yes", 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 family coverage elected. Use additional paper if needed.)

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

EVIDENCE OF INSURABILITY SECTION - PLEASE COMPLETE

(Coverage will not be considered unless ALL questions are answered.)

Non-Medical Questionnaire		
Cancer	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?	☐ Yes ☐ No
Please explain all "Yes" answers in the space provided on the next page. In your explanations, identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of applicable physician(s) and/or hospital(s).		
Cancer	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), or ever tested positive for antigens or antibodies to an AIDS virus?	☐ Yes ☐ No
Cancer	3. Is any person to be insured currently undergoing any diagnostic test for, now 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

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.
AWDIN4502-1

REQUIRED HEALTH HISTORY

***Include diagnosis, date(s), and duration along with name(s) and address(es) of all attending physicians and medical facilities. Use the additional space provided below if necessary.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATE(S) Including duration of illness	NAME(S) AND ADDRESS(ES) OF HOSPITAL(S) AND/OR PHYSICIAN(S)

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. · **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 to give to American Heritage Life, 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 coverages 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 enroll for it at a later date. Any such enrollment may be declined on the basis of such proof.

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