PLEASE COMPLETE ONLY THE GREEN HIGHLIGHTED SECTIONS

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FL 32224

Allstate. BENEFITS

Group Enrollment and Evidence of Insurability Form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State

Deduction Mode *(choose one)*: ☐ Monthly ☐ Semi-Monthly ☐ Weekly ☐ Bi-Weekly ☐ Other

Remarks	*AHL home office use only*	Dep Code ☐ E ☐ S ☐ C ☐ F

General Information

All references to spouse include domestic partner relationships.

Employee (Certificate holder) 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 Lake-Sumter State College	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 Life or Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Life or 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: ☐ Critical Illness ☐ Disability ☐ Hospital Indemnity

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Selection of Coverage *Answer yes or no and complete for each coverage selected.*

Critical Illness (GVCIP1) New Generation **Do you want this coverage?** ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Choose coverage:
- ☐ Critical Illness Cancer Option
- ☐ Recurrence Option
- ☐ Wellness Option Units _____

Basic Benefit Amount*: $ _____

☐ Plan 1 ☐ Plan 2

**If covered, basic benefit amount for spouse and other dependents is 50% of employee benefit.*

Home office use only

Critical Illness (GVCIP4) New Generation **Do you want this coverage?** ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Choose coverage:
- ☐ Cancer Critical Illness Option
- ☐ Reoccurrence of Critical Illness Option
- ☐ Second Evaluation, Transportation & Lodging Rider
- ☐ Reoccurrence of Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Rider with HIV
- ☐ Supplemental Critical Illness Rider without HIV
- ☐ Wellness Rider - Fixed Units _____
- ☐ Wellness Rider - Variable Units _____
- ☐ Skin Cancer Rider
- ☐ Cardiopulmonary Enhancement Rider
- ☐ Specified Chronic Illness Rider
- ☐ Specified Chronic Illness or Injury Rider
- ☐ Lifestyle Enhancement Rider

Basic Benefit Amount: $ _____

Home office use only

Disability (GVDIP Short-Term) New Generation **Do you want this coverage?** ☐ Yes ☐ No Section 125 ☐

Provide: Monthly Earnings* $ _____ Monthly Benefit $ _____

**Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.*

Total Deduction

Choose one: ☐ Plan 1 ☐ Plan 2

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No If yes, provide the company name:

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, provide the following: Company Name Year Issued

Monthly Benefit $ Elimination Period Benefit Period

Home office use only

Employee Name _____ Account No. _____

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Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Eligibility Questions *Answer each question for the coverages for which you are applying.*

Employee answer for the following: Critical Illness, Disability, Life

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

Spouse answer for the following: Life

Spouse Actively At Work. Is the employee's spouse 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? **Spouse** ☐ Yes ☐ No

Underwriting Questions for Life Coverage and Late Enrollment Health Coverage

*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. *For Critical Illness and Life, underwriting questions are not applicable to children.*

Answer for the following: Critical Illness, Disability, Life

1. **AIDS History.** In the last 5 years, has the person(s) to be insured tested positive for exposure to the HIV infection or been diagnosed by a licensed health care practitioner as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?
   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No

Answer for the following: Life

2. **Recently Disabled/Hospitalized.** In the last 6 months, has the person(s) to be insured been disabled or hospitalized for anything other than lacerations or broken bones due to an accident, or normal pregnancy?
   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No

Answer for the following: Life

3. **Chronic Disease History.** In the last 2 years, has a licensed health care practitioner diagnosed or treated the person(s) to be insured for any of the following?
   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No

   - Anemia (other than iron deficiency)
   - Anxiety, depression or other mental or nervous illness (that resulted in hospitalizations, disability from work, or suicide attempts)
   - Asthma (only if taking steroidal medication and/or have been hospitalized)
   - Cancer, except basal cell carcinoma
   - Diabetes
   - Epilepsy and/or seizure disorder
   - Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder
   - Hemophilia
   - Hepatitis
   - Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
   - Liver Disease/Disorder
   - Lou Gehrig's Disease (ALS)
   - Lung Disease/Disorder (other than asthma)
   - Lupus
   - Multiple Sclerosis
   - Muscular Dystrophy
   - Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia
   - Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation
   - Transplant of any organ
   - Counseling for, or excessive use of, alcohol or any type of drugs

Answer for the following: Critical Illness, Disability, Life

4. **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 licensed health care practitioner?
   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No

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Answer for the following: Life

5. **Driving History.** In the last 3 years, has the person(s) to be insured had his/her driver's license suspended or revoked due to driving violations, been convicted of reckless driving or driving under the influence, been involved in 3 or more motor vehicle accidents, or received 3 or more moving violations? If yes, provide details including license number and state of issue.

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

Answer for the following: Critical Illness Cancer Option

6a. **Cancer Diagnosis/Treatment History.** Has a licensed health care practitioner 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

6b. **Cancer Leukemia/Lymphoma.** If the answer to the Cancer Diagnosis/Treatment History question is yes, has a licensed health care practitioner 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

6c. **Cancer Other.** If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a licensed health care practitioner 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, Disability

7. **Major Medical Condition History.** In the last 2 years, has a licensed health care practitioner 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: Disability

8. **Back/Asthma History.** In the last 2 years, has the person(s) to be insured had any disease of, been impaired by, or received treatment from a licensed health care practitioner for, the following (other than minor illness)?

Employee ☐ Yes ☐ No

- Any disorder of the back or neck
- Asthma

Answer for the following: Critical Illness, Disability, Life

9. **Advised Medical Procedure History.** In the last 5 years, has a licensed health care practitioner 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

Answer for the following: Specified Chronic Illness Rider, Supplemental Critical Illness Benefits Rider

10. **Brain/Eye/Hearing Disorder History.** In the last 5 years, has a licensed health care practitioner diagnosed, advised, treated, or consulted the person(s) to be insured for any of the following?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

- 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

Answer for the following: Specified Chronic Illness Rider

11. **Specified Disease Critical Illness History.** In the last 2 years, has a licensed health care practitioner diagnosed or treated the person(s) to be insured for any of the following?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

- Addison's Disease
- Benign Brain Tumor
- Huntington's Disease
- Osteomyelitis
- Osteoporosis
- Lou Gehrig's Disease (ALS)

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Answer for the following: Disability

12. Pregnant/Fertility Treatment. Is the person(s) to be insured currently pregnant or undergoing fertility treatment? **Employee** ☐ Yes ☐ No

Provide height and weight.

13. Employee for the following: Life, Critical Illness, Disability **Height:** _____ ft. _____ in **Weight:** _____ lbs.

Answer for the following: Critical Illness* (over $50,000), EGTL* ($150,000 over GI)

14. Physician Information. Provide the names and addresses of all physicians (or other licensed health care practitioners) for each person to be insured. The required health history section may be used if additional space is needed.

Answer for the following: All products

15. Required Health History. Provide health history for any yes answers to the underwriting questions (except questions about AIDS). Include physician's (or other licensed health care practitioners') 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 contained in this form are representations, not warranties, and 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 agent (producer) 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 LIFE AND 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.

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee/Payor/Owner Signature | City/State | Date Signed

Proposed Insured Signature (if not employee/payor/owner and if required by your state or face amount being requested)