



**Allstate**

Benefits

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)**

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

**ENROLLMENT AND EVIDENCE OF INSURABILITY FORM**

New Certificate  Change/Increase Certificate # \_\_\_\_\_

Remarks:	This box for AHL Home Office use only
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**GENERAL INFORMATION**

Employee's/Payor's/Owner's (Certificateholder) Name (Last, First, M.I.)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	
Residence Address		City	State	Zip
Date of Birth	Phone Number	Email		
Employer/Association/Union <b>Sarasota County</b>		Date Hired	Occupation	Plant Or Division
Primary Beneficiary's Full Name and Address		City	State	Zip
		Relationship		
Phone Number	Date of Birth	Social Security Number		
Contingent Beneficiary's Full Name and Address		City	State	Zip
		Relationship		
Phone Number	Date of Birth	Social Security Number		

**COMPLETE THIS SECTION FOR PERSONS TO BE INSURED**

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number
		Employee			
		Spouse			

Are you changing any existing coverage due to a qualifying event such as marriage, birth, or adoption?  
**Accident**  Yes  No      **Cancer/Specified Disease**  Yes  No  
If "Yes", please complete the following: Qualifying Event \_\_\_\_\_  
Date of Qualifying Event \_\_\_\_\_ Current Certificate Number(s) \_\_\_\_\_

Do you currently have any of the following individual coverages with American Heritage Life Insurance Company (AHL)?  
Accident  Yes  No      Cancer  Yes  No  
If you answered "Yes" to any of the coverages, please enter the Policy Number \_\_\_\_\_  
Do you wish to terminate this coverage?  Yes  No      If "Yes", please enter effective date of termination \_\_\_\_\_

<b>Premium/Billing Mode</b> <input checked="" type="checkbox"/> Bi-weekly	Account Number	Employee ID	Situs State
Date of First Deduction _____ Coverage Effective Date _____			<b>FL</b>

## ENROLLMENT AND EVIDENCE OF INSURABILITY FORM SELECTION OF COVERAGE

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

<b>Accident (GVAP1)</b> (On and Off the Job Accident) <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units <u>2</u>	<b>Total Bi-weekly Premium: (26 Paychecks)</b> Employee Only <input type="checkbox"/> \$ 6.70 Employee+Spouse <input type="checkbox"/> \$12.42 Employee+Child(ren) <input type="checkbox"/> \$11.36 Family <input type="checkbox"/> \$17.06	Section 125 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Home Office Use Only</b>
<input checked="" type="checkbox"/> Benefit Enhancement Rider Units <u>2</u>				

<b>Cancer/Specified Disease (GVCP2)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					Section 125 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			<b>Home Office Use Only</b>		
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	<input checked="" type="checkbox"/> Cancer Initial Diagnosis Option	<input checked="" type="checkbox"/> Intensive Care Option	<input checked="" type="checkbox"/> Cancer Screening Option	<b>Total Bi-weekly Premium: (26 Paychecks)</b>		
<b>Units Low Plan:</b>	1	2	2	1	3	N/A	4	Employee Only <input type="checkbox"/> \$ 7.76	Family <input type="checkbox"/> \$13.14	
<b>Low Plan (with ICU):</b>	1	2	2	1	3	3	4	Employee Only <input type="checkbox"/> \$ 8.56	Family <input type="checkbox"/> \$14.78	
<b>High Plan:</b>	3	4	3	1	5	N/A	4	Employee Only <input type="checkbox"/> \$12.98	Family <input type="checkbox"/> \$21.92	
<b>High Plan (with ICU):</b>	3	4	3	1	5	6	4	Employee Only <input type="checkbox"/> \$14.62	Family <input type="checkbox"/> \$25.18	

### EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

Eligibility Question		EE	SP	CH
<b>Cancer</b>	1. Is any person to be insured (employee and the employee's spouse if applying for life and/or accident with sickness disability rider) 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 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	N/A
<b>If any of the questions below are answered "yes", please list the required health history on page 3.</b>				
Underwriting Questions		EE	SP	CH
<b>Cancer</b>	2. Has any person to be insured, in the last 10 years, 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Cancer w/ Intensive Care Option</b>	3. Has any person to be insured, in the last year, been diagnosed by a licensed health care practitioner with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Cancer &amp; Cancer Initial Diagnosis Option</b>	4a. Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any type of cancer, other than basal cell carcinoma?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	4b. If the answer to 4a. is yes, has that person(s) been diagnosed with or treated by a licensed health care practitioner for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	4c. If the answer to 4a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a licensed health care practitioner for any other type of cancer (other than those listed in 4b. and/or basal cell carcinoma)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

## ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

### EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

<b>If any of the questions below are answered "yes", please list the required health history in Question 8 below.</b>				
<b>Underwriting Questions (Continued)</b>		<b>EE</b>	<b>SP</b>	<b>CH</b>
<b>Cancer w/ Intensive Care Option</b>	5. Has any person to be insured, in the last 5 years, been diagnosed with or treated by a licensed health care practitioner 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"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Cancer</b>	6. Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any of the following? <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <ul style="list-style-type: none"> <li>Addison's Disease</li> <li>Brucellosis</li> <li>Cerebrospinal meningitis</li> <li>Cystic Fibrosis</li> <li>Encephalitis</li> <li>Hansen's Disease</li> <li>Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)</li> <li>Legionnaire's Disease</li> <li>Lou Gehrig's Disease (ALS)</li> <li>Lyme Disease</li> <li>Muscular Dystrophy</li> <li>Multiple Sclerosis</li> </ul> <ul style="list-style-type: none"> <li>Myasthenia Gravis</li> <li>Osteomyelitis</li> <li>Primary Biliary Cirrhosis</li> <li>Primary Sclerosing Cholangitis</li> <li>Reye's Syndrome</li> <li>Rocky Mountain Spotted Fever</li> <li>Sickle Cell Anemia</li> <li>Systemic Lupus Erythematosus</li> <li>Tetanus</li> <li>Tuberculosis</li> <li>Thalassemia</li> <li>Tularemia</li> <li>Typhoid Fever</li> </ul> </div>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Cancer w/ Intensive Care Option</b>	7. Provide Height and Weight of Proposed Insured:  Height:                      Weight:			
<b>Required Health History</b>	8. Provide health history for any "Yes" answers to the Underwriting questions (except question 2). Include physician's (or other licensed health care practitioners) name, address and telephone number:  _____			

### ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance and/or my policy(ies), including all documents accompanying my certificate(s) of insurance and/or my policy(ies). If electronically delivered, I understand that I will receive electronic delivery at the email address I provided instructions at the email address I have provided on how to receive my policy/certificate and accompanying documents at: [www.allstatebenefits.com/mybenefits](http://www.allstatebenefits.com/mybenefits).

Yes  No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) of insurance and/or my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive my correspondence at the last email address I have provided instructions at the last email address I have provided on how to receive correspondence at: [www.allstatebenefits.com/mybenefits](http://www.allstatebenefits.com/mybenefits).

Yes  No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate(s) of insurance and/or my policy(ies), free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

**REPRESENTATION.** I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers contained in this application 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, American Heritage Life 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 application may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.

**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.**

Signed at: City/State \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Proposed Insured \_\_\_\_\_

Signature of Owner, if other than Insured \_\_\_\_\_

Signature of Employee/Payor, if not Insured or Owner \_\_\_\_\_

**Agent's (Producer's) Statement.** I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Florida Agent (Producer) \_\_\_\_\_

Print Soliciting Agent (Producer) Name \_\_\_\_\_

Florida Agent License Number \_\_\_\_\_

To be completed by home office or agent (producer), prior to issue:

Agent (Producer) Name	Agent (Producer) Number	National Agent (Producer) Number (NPN)	Percentage Credit
Servicing Agent (Producer):	7HXG0		50 %
Soliciting Agent (Producer):	7TCF0		50 %
			%
			%
			%



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6688  
(904) 992-1776

A Stock Company

### IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

#### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- Hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

#### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).



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A Stock Company

<p><b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b></p>
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### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

<p><b>Before You Buy This Insurance</b></p>
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- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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