



**Allstate**

Workplace Division

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

**ENROLLMENT AND EVIDENCE OF INSURABILITY FORM**  
Group Universal Life

**EMPLOYEE/MEMBER INFORMATION SECTION**  
(Please complete entire section)

- New Certificate
- Change Certificate \_\_\_\_\_
- Reinstatement \_\_\_\_\_

Please print with black ink

EMPLOYEE/MEMBER NAME Last First M.I.			<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YYYY)	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENCE ADDRESS			CITY		STATE	ZIP
EMPLOYER/ASSOCIATION/UNION			DATE HIRED (MM/DD/YEAR)		PHONE NUMBER	
OCCUPATION			PLANT OR DIVISION		ANNUAL SALARY \$	
Are you actively at work now and have you worked at least 20 hours each week performing all your duties at your regular occupation at your 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 If not, why? _____						

**PROPOSED INSURED'S INFORMATION SECTION**

(Please complete entire section unless employee/member is proposed insured; then complete information not provided above)

NAME (Last, First, M.I.)			<input type="checkbox"/> Emp./Mem. <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	AGE	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YYYY)
RESIDENCE ADDRESS			CITY		STATE	ZIP	
OCCUPATION		EMPLOYER		ANNUAL SALARY \$		PHONE NUMBER	
OWNER'S NAME AND RESIDENCE ADDRESS			CITY		STATE	ZIP	
PRIMARY BENEFICIARY FULL NAME		AGE	RELATIONSHIP	CONTINGENT BENEFICIARY FULL NAME		AGE	RELATIONSHIP
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 _____							

**DEPENDENT COVERAGE SECTION**

(Please complete if children's term and/or other insured's term rider coverage elected. Use additional paper if needed.)

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

**SELECTION OF COVERAGE SECTION**

<input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> GI (Employee only)					Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2			Face Amount \$		Mode Premium \$
<b>Universal Life</b> _____					Rider			Rider		
Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider		
Units/Amt										
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? _____								Remarks		

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

# ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

## EVIDENCE OF INSURABILITY SECTION

(If question 1 is answered "No" or questions 2-6 are answered "Yes", please list the requested information in 8 below.)

<b>Eligibility - Spouse Only</b>															
1.	Is the 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
<b>Contingent Guaranteed Issue (Must answer questions 2, 3, 9 and 10)</b>															
2.	Has any person to be insured been tested positive for exposure to the HIV infection or been diagnosed 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"/> Yes <input type="checkbox"/> No												
3.	Has any person to be insured been disabled or hospitalized in the last 6 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
<b>Simplified Issue (Must answer questions 2-10)</b>															
4a.	In the last 3 years, has any person to be insured: been treated by a licensed medical provider for a chronic disease (including but not limited to heart disorder, stroke, cancer, diabetes, etc.); been hospitalized; seen a physician (other than for colds, flu or normal pregnancy or a routine physical with no unfavorable results); or been counseled by a member of the medical profession or in an accredited alcohol or drug rehabilitation program for alcohol or any type of drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
b.	Is any person to be insured currently under the care or treatment of a physician (including but not limited to currently using prescription medications for injury or illness)?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
c.	Has any person to be insured ever been rated or declined for life insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
5a.	Has any person to be insured ever been diagnosed by a physician with hypertension or high blood pressure?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
b.	If the answer to 5a is yes, in the last year has that person had 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"/> Yes <input type="checkbox"/> No												
6.	Please provide person to be insured's height and weight:                      Height:                      Weight:														
7.	Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details.  _____		<input type="checkbox"/> Yes <input type="checkbox"/> No												
8.	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">Name</td> <td style="width: 35%; border: none;">Nature of Illness/Injury or Medical Attention/ Reason Last Consulted</td> <td style="width: 20%; border: none;">Date and/or Duration</td> <td style="width: 20%; border: none;">Name and Address of Physician or Hospital/Clinic</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Name	Nature of Illness/Injury or Medical Attention/ Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic	_____	_____	_____	_____	_____	_____	_____	_____		
Name	Nature of Illness/Injury or Medical Attention/ Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic												
_____	_____	_____	_____												
_____	_____	_____	_____												
<b>Replacement and Existing Insurance Section (Must Answer)</b>															
9.	<b>Replacement.</b> Is this insurance to replace or change any existing life coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state.  _____		<input type="checkbox"/> Yes <input type="checkbox"/> No												
10.	<b>Existing Insurance.</b> Is there any other life insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.  _____ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No												

## ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

### CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS (Please read, sign and date)

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 to the best of my knowledge and belief. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL 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 insurance being applied for will be effective as of the enrollment form date, provided the person(s) to be insured is (are) found acceptable for such insurance as applied for. • 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 AHL, its subsidiaries or its reinsurers, any information. 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 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 AHL 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. 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. **FRAUD WARNING: 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 or Payor, if other than Insured: \_\_\_\_\_

- Producer's Statement.** (Must complete)
1. To your knowledge, is change or replacement involved?  Yes  No
  2. To your knowledge, does the proposed insured have existing coverage in force?  Yes  No
  3. I certify that to the best of my knowledge and belief the information on this enrollment form is complete, accurate and correctly recorded.

Signature of Producer: \_\_\_\_\_ Print Producer's Name: \_\_\_\_\_

**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. No information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this coverage except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing prove positive.

**GIN/MIB**

**(03/08)**

**MIB NOTICE:**

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (Bureau), a non-profit 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. 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 P.O. Box 105, Essex Station, Boston, MA 02112, PH. 866-692-6901 (TTY 866-346-3642 for hearing impaired). American Heritage Life Insurance Company or its reinsurers may release information in its file to other 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.

**GIN/MIB**

**(03/08)**



**Allstate**<sup>®</sup>

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