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

GENERAL INFORMATION

Employee's/Payor's/Owner's (Certificateholder) Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth	Phone Number	Email	
Employer/Association/Union Augusta County Schools	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	Tobacco Use*
		Employee				** ☐ Yes ☐ No
		Spouse/ Domestic Parnter				** ☐ Yes ☐ No

***Has anyone to be insured used tobacco in the last 12 months? (**If applying for Critical Illness.)**

Are you changing any existing coverage due to a qualifying event such as marriage, birth, or adoption?

Accident ☐ Yes ☐ No **Universal Life** ☐ Yes ☐ No

Critical Illness ☐ 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 Critical Illness ☐ 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 ____________

Premium/Billing Mode	Account Number	Employee ID	Situs State
☒ Monthly Date of First Deduction ____________ Coverage Effective Date ____________	V4889		VA

(EOI L70PA)
ABJ4580VA2

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM
SELECTION OF COVERAGE

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

Accident 1 (GVAP1) (On and Off the Job Accident) ☐ Yes ☐ No	Base Units 2	**Total Monthly Premium:**		Section 125	**Home Office Use Only**
		Employee Only	☐ $17.99	☐ Yes ☒ No	
		Employee+Spouse	☐ $33.86		
		Employee+Child(ren)	☐ $36.84		
		Family	☐ $44.89		
☒ Benefit Enhancement Rider Units 1					

Critical Illness (GVCIP2) ☐ Yes ☐ No	**Basic Benefit Amount:** ☐ **$10,000** -or- ☐ **$20,000** If covered, Basic Benefit amount for spouse or other dependents is 50% of the employee's.	Section 125 ☐ Yes ☒ No	**Home Office Use Only**
☒ Cancer Critical Illness Option	☒ 2nd Event Initial Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 4

Monthly Premiums **$10,000 Basic Benefit**	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 12.79	☐ $ 21.45	☐ $ 12.79	☐ $ 21.45
	30-35	☐ $ 12.84	☐ $ 21.52	☐ $ 12.84	☐ $ 21.52
	36-39	☐ $ 24.54	☐ $ 39.07	☐ $ 24.54	☐ $ 39.07
	40-50	☐ $ 24.85	☐ $ 39.54	☐ $ 24.85	☐ $ 39.54
	51-54	☐ $ 47.89	☐ $ 74.09	☐ $ 47.89	☐ $ 74.09
	55-60	☐ $ 48.90	☐ $ 75.61	☐ $ 48.90	☐ $ 75.61
	61-63	☐ $ 75.61	☐ $115.68	☐ $ 75.61	☐ $115.68
	64-70	☐ $112.36	☐ $170.79	☐ $112.36	☐ $170.79
	71+	☐ $114.56	☐ $174.10	☐ $114.56	☐ $174.10
Tobacco	18-29	☐ $ 17.61	☐ $ 28.67	☐ $ 17.61	☐ $ 28.67
	30-35	☐ $ 17.69	☐ $ 28.79	☐ $ 17.69	☐ $ 28.79
	36-39	☐ $ 37.91	☐ $ 59.12	☐ $ 37.91	☐ $ 59.12
	40-50	☐ $ 38.45	☐ $ 59.93	☐ $ 38.45	☐ $ 59.93
	51-54	☐ $ 76.94	☐ $117.67	☐ $ 76.94	☐ $117.67
	55-60	☐ $ 78.65	☐ $120.33	☐ $ 78.65	☐ $120.23
	61-63	☐ $114.18	☐ $173.53	☐ $114.18	☐ $173.53
	64-70	☐ $171.17	☐ $259.01	☐ $171.17	☐ $259.01
	71+	☐ $174.70	☐ $264.31	☐ $174.70	☐ $264.31

Monthly Premiums **$20,000 Basic Benefit**	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 19.07	☐ $ 30.86	☐ $ 19.07	☐ $ 30.86
	30-35	☐ $ 19.16	☐ $ 31.00	☐ $ 19.16	☐ $ 31.00
	36-39	☐ $ 42.56	☐ $ 66.10	☐ $ 42.56	☐ $ 66.10
	40-50	☐ $ 43.16	☐ $ 67.01	☐ $ 43.16	☐ $ 67.01
	51-54	☐ $ 89.24	☐ $136.13	☐ $ 89.24	☐ $136.13
	55-60	☐ $ 91.28	☐ $139.13	☐ $ 91.28	☐ $139.18
	61-63	☐ $144.70	☐ $219.31	☐ $144.70	☐ $219.31
	64-70	☐ $218.18	☐ $329.54	☐ $218.18	☐ $329.54
	71+	☐ $222.59	☐ $336.15	☐ $222.59	☐ $336.15
Tobacco	18-29	☐ $ 28.69	☐ $ 45.30	☐ $ 28.69	☐ $ 45.30
	30-35	☐ $ 28.84	☐ $ 45.53	☐ $ 28.84	☐ $ 45.53
	36-39	☐ $ 69.30	☐ $106.21	☐ $ 69.30	☐ $106.21
	40-50	☐ $ 70.39	☐ $107.84	☐ $ 70.39	☐ $107.84
	51-54	☐ $147.32	☐ $223.26	☐ $147.32	☐ $223.26
	55-60	☐ $150.77	☐ $228.42	☐ $150.77	☐ $228.42
	61-63	☐ $221.84	☐ $335.02	☐ $221.84	☐ $335.02
	64-70	☐ $335.81	☐ $505.89	☐ $335.81	☐ $505.98
	71+	☐ $342.89	☐ $516.59	☐ $342.89	☐ $516.59

Layoff Rider: ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE

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

Abbreviations: CGI - Contingent Guaranteed Issue GI - Guaranteed Issue SI - Simplified Issue

Life ☐ Universal Life (UL)	**Home Office Use Only**
☐ Yes ☐ No ☐ GI (Employee only) ☐ SI	

Death Benefit Option ☐ 1 ☐ 2 (UL ONLY) Employee's Annual Salary $ ____________

Employee

Face Amount:

			Total Monthly Premium
☐ $25,000	☐ $100,000	☐ Other $ ____________	
☐ $50,000	☐ $125,000		
☐ $75,000	☐ $150,000		$ ______________

Life Riders	Rider GULBR	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt								

Replacement and Existing Insurance Section (Must Answer)

1a. Replacement. Proposed Insured. Is this insurance to replace, discontinue or change any existing life or annuity coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state. ____	☐ Yes ☐ No
1b. Producer. To your knowledge, is change or replacement of life or annuity coverage involved?	☐ Yes ☐ No
2a. Existing Insurance. Proposed Insured. Is there any other (not listed in Question 1a.) life or annuity coverage in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit and complete replacement form provided by your producer, if required by your state. ____	☐ Yes ☐ No
2b. Producer. To your knowledge, does the proposed insured have existing coverage in force?	☐ Yes ☐ No

Illustration Regulation Certification (Must Answer for Universal Life only)

3a. Illustration Certification. Owner. The owner certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate. If no, complete the applicable illustration certification form provided, if required in your state.	☐ Yes ☐ No
3b. Producer. The Producer certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate. If no, complete the applicable illustration certification form provided, if required in your state.	☐ Yes ☐ No

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

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

	Eligibility Question	EE	SP	CH
GI & SI Life	**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?	☐Y ☐N	N/A	N/A

If any of the questions below are answered "yes", please list the required health history below.

	Underwriting Questions	EE	SP	CH
SI Life	**2.** Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	☐Y ☐N	N/A	N/A
SI Life	**3.** Has any person to be insured, in the last 2 years, been diagnosed or treated by a member of the medical profession for any of the following? • Anemia (other than iron deficiency) • Anxiety, depression or other mental or nervous illness (that would include hospitalizations, disability from work, or suicide attempts) • Asthma (other than taking non-steroidal medication as needed with no hospitalizations), or any other lung disorder • Cancer, except basal cell carcinoma • Diabetes • Epilepsy with a seizure within the last 2 years • 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 involving dialysis or chronic renal failure • Liver Disease • Lou Gehrig's Disease (ALS) • 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	☐Y ☐N	N/A	N/A
SI Life	**4.** Has any person to be insured, in the last 3 years: had his/her driver's license suspended or revoked; been convicted of reckless or drunken driving; or been involved in 3 or more motor vehicle accidents?	☐Y ☐N	N/A	N/A
SI Life	**5.** Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a member of the medical profession, but not done at this time?	☐Y ☐N	N/A	N/A
SI Life (over $150,000)	**6.** Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured; the required health history section may be used if additional space is needed. ____________________			
Required Health History	**7.** Provide health history for any "Yes" answers to the Underwriting questions. Include physician's (or other members of the medical profession) 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, including all documents accompanying my certificate(s) of insurance. If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my certificate and accompanying documents at: 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, 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 instructions at the last email address I have provided on how to receive correspondence at: 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, 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. The undersigned producer and I certify that 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 given on this application 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 producer (agent) has authority to waive any answer or otherwise modify this application, or to bind American Heritage Life Insurance Company 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. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, or the Medical Information Bureau (MIB, Inc.), that has records or knowledge of me or my health including my prescription medication history to give to American Heritage Life Insurance Company, its subsidiaries or its reinsurers any information relating to the underwriting of insurance for which I am applying. I also authorize American Heritage Life Insurance Company, 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. I or my authorized representative may request a copy of this authorization. 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 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.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Caution: If your answers on this application are incorrect or untrue, American Heritage Life Insurance Company has the right to deny benefits or rescind your certificate.

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 ______________________

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 Producer ______________________ Print Soliciting Producer Name ______________________

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

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer:			%
Soliciting Producer:			%
			%
			%
			%

(EOI L70PA)
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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. The purpose of this information is to determine your eligibility for insurance. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You may request to be interviewed in connection with the preparation of the investigative report and 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. You or your representative are entitled to receive a copy of this investigative consumer report upon your request.

IN/MIBVA-3 **(2012)**

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901. American Heritage Life 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.

IN/MIBVA-3 **(2012)**

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).