# 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 # ________________

## GENERAL INFORMATION

| Employee's Name (Last, First, M.I.) | | | ☐ M ☐ F | Social Security Number |
|---|---|---|---|---|
| Residence Address | | City | State | Zip |
| Date of Birth | Phone Number | Email | | |
| Employer/Association/Union | Date Hired | Occupation | Plant Or Division | |

## COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

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

| Date of First Deduction | Coverage Effective Date | Account Number | Employee ID | Situs State |
|---|---|---|---|---|
| ________________ | ________________ | | | NC |

## SELECTION OF COVERAGE

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

| **Cancer/Specified Disease** **(GVCP2)** ☐ Yes ☐ No | ☐ Basic ☐ Premium ☐ Enhanced | ☐ Employee Only ☐ Family | Total Monthly Premium $ ________________ |
|---|---|---|---|
| ☒ Cancer Screening Option | | | |

# 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

| | Eligibility Question | EE | SP | CH |
|---|---|---|---|---|
| **Cancer** | **1.** 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? | ☐Y ☐N | N/A | N/A |

**If any of the questions below are answered "yes", please list the required health history on page 2.**

| | Underwriting Questions | EE | SP | CH |
|---|---|---|---|---|
| **Cancer** | **2.** Has any person to be insured, in the last 5 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 | ☐Y ☐N | ☐Y ☐N |
| **Cancer** | **3a.** Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| | **3b.** If the answer to 3a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| | **3c.** If the answer to 3a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 3b. and/or basal cell carcinoma)? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **Cancer** | **4.** Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any of the following?<br>• Addison's Disease<br>• Brucellosis<br>• Cerebrospinal meningitis<br>• Cystic Fibrosis<br>• Encephalitis<br>• Hansen's Disease<br>• Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)<br>• Legionnaires' Disease<br>• Lou Gehrig's Disease (ALS)<br>• Lyme Disease<br>• Muscular Dystrophy<br>• Multiple Sclerosis<br>• Myasthenia Gravis<br>• Osteomyelitis<br>• Primary Biliary Cirrhosis<br>• Primary Sclerosing Cholangitis<br>• Reye's Syndrome<br>• Rocky Mountain Spotted Fever<br>• Sickle Cell Anemia<br>• Systemic Lupus Erythematosus<br>• Tetanus<br>• Tuberculosis<br>• Thalassemia<br>• Tularemia<br>• Typhoid Fever | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **Required Health History** | **5.** 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: ______ | | | |

**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 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 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.

Signed at: City/State ______________________ Date Signed ______________________

Signature of Proposed Insured ______________________