Allstate
Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

GROUP VOLUNTARY CANCER PORTABILITY PRIVILEGE

This overview provides important information on benefits that may be continued in accordance with the Portability Provision of the Group Policy under which you have been insured. It explains who is eligible, when eligible and how to request Portability coverage.

Eligibility

Employee Continuation (with or without Dependent Coverage)

To be eligible for the Portability coverage:

1. coverage under the group policy terminates as per the General Provision entitled "Termination of Coverage";
2. we receive a written request and payment of the first premium for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

If you elect Portability for yourself, you may also elect to continue coverage for your spouse and dependent children. To be eligible for Portability, your spouse or dependent child must have been insured under the Group Policy immediately prior to your election of portability for them. You may *not* elect to *add* Spouse or Dependent Children's benefits at the time you apply for Portability.

Dependent Continuation

This also applies to dependents who cease to meet the qualifications as described under Eligibility of Dependents in the Group Policy because of an employee's death, divorce, a child's attainment of the maximum age, etc. A dependent in this category is eligible to apply for Portability coverage in his or her own name.

Portability Coverage

If you exercise your Portability Privilege, the benefits, terms and conditions of the Portability coverage will be the same as those currently provided under the Group Policy. Any change made to the policy after a person is insured under the Portability Privilege will not apply to that insured unless it is required by law.

Exercising Your Portability Privilege

To exercise your Portability privilege, complete the attached form AWD3299GVC-REQ, GROUP VOLUNTARY CANCER - REQUEST TO EXERCISE PORTABILITY PRIVILEGE. Make a copy of the Request form and retain it for your records. Mail the "original" form along with your check or money order for the premium to us at the address below. The time limit for doing this is 30 days after the date your employment terminated. Requests received after this will be denied, unless the period for making the request is extended for your case by law.

Premium Administration Department
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

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MONTHLY PREMIUM RATES APPLICABLE TO INSURED PERSONS WHO EXERCISE THE PORTABILITY PRIVILEGE UNDER

Group Policy No.: 83126

Group Policyholder: NC Flex

MONTHLY PREMIUM FOR **GROUP VOLUNTARY CANCER** INSURANCE

Low Package:	Individual Only	$6.78
	Family	$11.26
High Package:	Individual Only	$15.68
	Family	$26.06
Premium Package:	Individual Only	$21.64
	Family	$35.96

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GROUP VOLUNTARY CANCER - REQUEST TO EXERCISE PORTABILITY PRIVILIEGE

1. Applicant Name:_____ Date of Birth ___/___/___ Sex _____
Last First M.I. Mo/Day/Yr

2. Mailing Address: _____ Telephone (____) _____
Street or P.O. Box (Area Code)

_____ Social Security No. or Certificate Number _____
City County State Zip

3. Applicant's email address: _____

4. Former Employer: State of North Carolina (NC FLEX) Group Number 83126

5. Reason Your Coverage Terminated:_____

Date your COBRA Continuation was exhausted, if applicable: _____

6. Were you covered as a dependent of another person? ____ Yes ____ No

If yes, what is the name of that person and their Group Voluntary Cancer Certificate Number?

Name:_____ Social Security No. or Certificate Number: _____
Last First M.I.

7. Premium Amount Enclosed: $_____ (See attachment for monthly premiums.) **Please note that premiums must accompany this request. (*Future payments may be made by automatic bank draft by completing Payment Authorization form AWD062-1*.)

8. Mode Premium Payment: ☐ Annual Direct Bill; ☐ Monthly Direct Bill;or ☐ Monthly Bank Draft. If bank draft, complete the AWD062-1 form.

9. List each dependent to be insured and provide information requested in the table below.

Dependents Name (Last, First, M. I.)	**Relationship**	**SEX**	**Date of Birth** (MM/DD/YR)	**Social Security Number**

Use a blank sheet of paper for additional dependents, if needed.

10. READ AND SIGN BELOW.

I hereby request the portability coverage indicated. I represent that the statements in this request are true and complete to the best of my knowledge and belief. In making this request, I understand and agree that: (a) premiums paid by check are not, for purposes of coverage, deemed paid unless collected by the American Heritage Life Insurance Company (AHL), but upon collection, will be deemed paid as of the date of AHL's receipt of the check at its Home Office; (b) AHL may promptly deposit any premium payment, and such deposit will not make AHL liable for claim or prejudice or waive AHL's right to disapprove this request and refund such payment if I am not entitled to the coverage or have failed otherwise to satisfy the applicable requirements; and (c) no agent or other person may alter or waive any terms, benefits, or requirements of the coverage or bind AHL by making any promise or giving any information, unless such alteration, waiver, promise or information is given in writing and signed by the president, vice president or secretary of AHL.

Signature of Person Making Request: _____

Print Name: _____

Signed at: _____ Date: _____
City *State*

11. Mail this form to the Premium Administration Department at American Heritage Life Insurance Company, 1776 American Heritage Life Dr., Jacksonville FL 32224.

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224
1-800-521-3535

Optional Payment Authorization

Use this form to authorize us to electronically deduct money from your checking or savings account to pay for American Heritage Life Insurance Company coverages.

1. Account Holder Information

Account Holder Name:_____ Phone:_____

Address:_____ State:_____ ZIP:_____

2. Account Information

Name of Financial Institution:_____

Branch Address:_____ State:_____ ZIP:_____

ACH/Routing Number_____ Account Number:_____ ☐ Checking ☐ Savings

Attach a VOIDED check for checking account deductions.

3. Deduction Information

Please choose the day of the month for the deductions:_____ (Choose any day 1–28.)

Deductions will be made monthly for the following policies:

Policy Number	Policyholder Name	Monthly Premium

Total Monthly Deduction: _____

If account holder is different from owner, please describe relationship:_____

4. Authorization

I authorize American Heritage Life Insurance Company ("AHL") to initiate debit entries electronically to my account monthly in the amount indicated above and I authorize the financial institution named above to debit same to such account. This authorization remains effective and in full force until AHL and the financial institution have received written notification from me of its termination in such time and in such manner to afford AHL and the financial institution a reasonable opportunity to act on it.

Account Holder Signature:_____ Date:_____

5. Deliver this authorization to:

Fax to: 1-866-428-2516
Attn: Premium Administration Team 2

Mail to: Allstate Workplace Division
Attn: Premium Administration Team 2
1776 American Heritage Life Drive
Jacksonville, FL 32224