



# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

# Allstate

Workplace Division

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

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks

### GENERAL INFORMATION SECTION

(Please complete entire section for all coverages)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	SEX	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)		RESIDENT PHONE NUMBER		EMPLOYER <b>Chicago Police</b>		DATE OF HIRE (MM/DD/YEAR)
HEIGHT	WEIGHT	JOB TITLE		PLANT OR DIVISION	REHIRE DATE (MM/DD/YEAR)	
EMPLOYEE'S EMAIL			BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?  
**Group Voluntary Accident**     Yes    No    **Group Voluntary Cancer/Specified Disease**     Yes    No

If "Yes", please complete the following: Qualifying Event \_\_\_\_\_  
Date of Qualifying Event \_\_\_\_\_ Current Certificate Number \_\_\_\_\_

Do you currently have any of the following individual products with AHL?  
Accident  Yes  No    Cancer  Yes  No

If you answered "Yes" to any of the products, please enter the Policy Number \_\_\_\_\_

Do you wish to terminate this coverage?  Yes  No    If "Yes", please enter effective date of termination \_\_\_\_\_

### PLEASE COMPLETE FOR PERSONS TO BE INSURED

(Use additional paper if needed.)

Choose Plan(s):		Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number	Actively At Work*
Accident	Cancer						
			Employee				<input type="checkbox"/> Yes <input type="checkbox"/> No
			Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No
							N/A
							N/A
							N/A

\*Actively at work means that he/she is actively at work now for wage or profit and has 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.

<b>Premium/Billing Mode</b>  <input checked="" type="checkbox"/> Monthly  Date of Issue _____	Case Number	Agent Number	Percentage Credit
	Employee Number		
	Situs State <b>IL</b>		

# EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

## SELECTION OF COVERAGE SECTION

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

<b>Cancer/Specified Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Total Monthly Premiums:</b>					
			Low Option	Median Option	High Option		
		Employee	<input type="checkbox"/> \$18.37	<input type="checkbox"/> \$30.56	<input type="checkbox"/> \$44.70		
		Employee + Spouse	<input type="checkbox"/> \$29.04	<input type="checkbox"/> \$48.17	<input type="checkbox"/> \$70.53		
		Employee + Child(ren)	<input type="checkbox"/> \$25.44	<input type="checkbox"/> \$43.31	<input type="checkbox"/> \$64.08		
		Family	<input type="checkbox"/> \$36.09	<input type="checkbox"/> \$60.90	<input type="checkbox"/> \$89.88		
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input checked="" type="checkbox"/>	Intensive Care Option <input checked="" type="checkbox"/>	Wellness Benefit Option <input checked="" type="checkbox"/>
<b>Units</b>							
Low Option	<b>1</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>4</b>
Median Option	<b>1</b>	<b>6</b>	<b>1</b>	<b>1</b>	<b>5</b>	<b>4</b>	<b>4</b>
High Option	<b>1</b>	<b>9</b>	<b>1</b>	<b>1</b>	<b>10</b>	<b>6</b>	<b>4</b>

<b>Accident</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Base Units:</b>			<b>Total Monthly Premiums:</b>					
		Plan 1: 2 Units				Plan 1	Plan 2	Plan 3	Plan 4	
		Plan 2: 2 Units, with 1 unit of Benefit Enhancement Rider			Employee	<input type="checkbox"/> \$15.52	<input type="checkbox"/> \$17.99	<input type="checkbox"/> \$22.20	<input type="checkbox"/> \$27.14	
		Plan 3: 3 Units			Employee + Spouse	<input type="checkbox"/> \$28.88	<input type="checkbox"/> \$33.86	<input type="checkbox"/> \$42.24	<input type="checkbox"/> \$52.21	
		Plan 4: 3 Units, with 2 unit of Benefit Enhancement Rider			Employee + Child(ren)	<input type="checkbox"/> \$31.86	<input type="checkbox"/> \$36.84	<input type="checkbox"/> \$46.70	<input type="checkbox"/> \$56.67	
					Family	<input type="checkbox"/> \$39.28	<input type="checkbox"/> \$44.89	<input type="checkbox"/> \$57.84	<input type="checkbox"/> \$69.05	

## EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected.)

<b>If any of the questions 1-4 below are answered "yes", please list the required health history on the next page.</b>		
<b>Cancer</b>	1. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cancer</b>	2a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cancer</b>	3. Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thalassemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Intensive Care Option (Cancer Only)</b>	4a. Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

### REQUIRED HEALTH HISTORY

**\*Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

---

**Use this space for any additional explanation of questions 1-4 on page 2. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.**

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

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).

My consent is valid while I am covered under the group policy. 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, 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.

- YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.
- NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.

### CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

**I CERTIFY** that the statements and answers provided 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. 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 evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **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 American Heritage Life, it's subsidiaries or its reinsurers any information. 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 American Heritage Life 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 coverages requested. 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.

Employee's Signature \_\_\_\_\_ Signed at \_\_\_\_\_ Date Signed \_\_\_\_\_  
(City and State)