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

Group Enrollment and Evidence of Insurability Form

☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
V8582						VA

Deduction Mode: ☒ Other 10thly

Remarks	*AHL home office use only*	Dep Code ☐ E ☐ S ☐ C ☐ F

General Information

Employee Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union: Danville Public Schools	Hire Date	Occupation*	

Occupation with the employer in the General Information section.

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Critical Illness, has the employee's spouse used tobacco in the last 12 months? **Spouse** ☐ Yes ☐ No

Qualifying Life Event

Are you applying for coverage or changing existing coverage due to a qualifying event? ☐ Yes ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination ☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying event date ____ Current certificate number(s) ____

Termination of Current Coverage

Do you currently have any individual coverages with American Heritage Life Insurance Company that you wish to terminate in conjunction with this enrollment for group coverage? ☐ Yes ☐ No

If yes, enter the following information: Effective date of termination ____ Policy Number ____

Select the type of coverage: ☐ Accident ☐ Cancer ☐ Critical Illness ☐ Disability

Employee Name _________ Account No. V8582

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

Accident (GVAP2 Off the Job Accident)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☒

Choose coverage amount:

Total Tenthly Deductions	Plan 1
Employee Only	☐ **$22.23**
Employee + Spouse	☐ **$32.33**
Employee + Child(ren)	☐ **$44.98**
Family	☐ **$56.24**

Your coverage will consist:

	Units
Base Coverage	3
☒ Benefit Enhancement Option	2
☒ Outpatient Physician's Rider	4

Cancer/Specified Disease (GVCP3)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☒

Choose coverage amount:

Total Tenthly Deductions	Plan 1	Plan 2
Employee Only	☐ **$34.08**	☐ **$ 55.83**
Employee + Spouse	☐ **$56.56**	☐ **$ 89.99**
Employee + Child(ren)	☐ **$46.73**	☐ **$ 78.40**
Family	☐ **$69.84**	☐ **$113.19**

Your coverage will consist of:

	Plan 1	Plan 2
Hospital	2	3
Radiation/Chemotherapy	4	8
Surgery Related	1	2
Miscellaneous	1	1
Cancer Initial Diagnosis Option	2	6
Intensive Care Option	6	6
Wellness Option	2	2
Cancer Progressive Benefit Option	1	1

Critical Illness (GVCIP2)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☒

Your coverage will consist of:

☒ Second Event Initial Critical Illness Option

☒ Wellness Option Units 2

☒ Supplemental Critical Illness Option II

Choose basic benefit amount: ☐ $10,000 ☐ $20,000

Tenthly Deductions	$10,000 Basic Benefit Non-Tobacco				$10,000 Basic Benefit Tobacco			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	☐ $ 5.82	☐ $ 8.88	☐ $ 5.82	☐ $ 8.88	☐ $ 8.10	☐ $ 12.30	☐ $ 8.10	☐ $ 12.30
36-50	☐ $13.38	☐ $ 20.22	☐ $13.38	☐ $ 20.22	☐ $ 20.70	☐ $ 31.20	☐ $ 20.70	☐ $ 31.20
51-60	☐ $27.18	☐ $ 40.92	☐ $27.18	☐ $ 40.92	☐ $ 43.38	☐ $ 65.22	☐ $ 43.38	☐ $ 65.22
61-63	☐ $44.46	☐ $ 66.84	☐ $44.46	☐ $ 66.84	☐ $ 66.54	☐ $ 99.96	☐ $ 66.54	☐ $ 99.96
64+	☐ $70.14	☐ $105.36	☐ $70.14	☐ $105.36	☐ $105.90	☐ $159.00	☐ $105.90	☐ $159.00

Tenthly Deductions	$20,000 Basic Benefit Non-Tobacco				$20,000 Basic Benefit Tobacco			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	☐ $ 8.94	☐ $ 13.56	☐ $ 8.94	☐ $ 13.56	☐ $ 13.48	☐ $ 20.38	☐ $ 13.48	☐ $ 20.38
36-50	☐ $ 24.06	☐ $ 36.24	☐ $ 24.06	☐ $ 36.24	☐ $ 38.70	☐ $ 58.20	☐ $ 38.70	☐ $ 58.20
51-60	☐ $ 51.68	☐ $ 77.66	☐ $ 51.68	☐ $ 77.66	☐ $ 84.08	☐ $126.26	☐ $ 84.08	☐ $126.26
61-63	☐ $ 86.24	☐ $129.50	☐ $ 86.24	☐ $129.50	☐ $130.41	☐ $195.75	☐ $130.41	☐ $195.75
64+	☐ $137.57	☐ $206.51	☐ $137.57	☐ $206.51	☐ $209.09	☐ $313.79	☐ $209.09	☐ $313.79

Employee Name ________ Account No. V8582

Group Enrollment and Evidence of Insurability Form

Disability (GVDIP Short-Term) My Lifeline

Do you want this coverage? ☐ Yes ☐ No Section 125 ☒

Provide: Monthly Earnings* $ __________ Monthly Benefit $ __________

Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.

Elimination Period: **14** Days Accident **14** Days Sickness Benefit Period: **3** Months

Total Deduction

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No If yes, provide the company name: ____________

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, provide the following: Company Name ____________ Year Issued ____________

Monthly Benefit $ ____________ Elimination Period ____________ Benefit Period ____________

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Eligibility Questions

Answer each question for the coverages for which you are applying.

Employee answer for the following: Cancer, Disability

Employee Actively At Work. 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?

Employee ☐ Yes ☐ No

Underwriting Questions

Answer each question for the coverages for which you are applying. If any of the questions below are answered yes, list the required health history at the end of the section.

Answer for the following: Cancer, Disability

1. **AIDS History.** In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for Acquired Immune Deficiency Syndrome (AIDS), or has the person(s) to be insured tested positive for antigens or antibodies to an AIDS virus?

   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No
   Child(ren) ☐ Yes ☐ No

Answer for the following: Cancer w/Intensive Care Option, Disability

2. **Blood Pressure History.** In the last year, has the person(s) to be insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once that was confirmed by a member of the medical profession?

   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No
   Child(ren) ☐ Yes ☐ No

Group Enrollment and Evidence of Insurability Form

Answer for the following: Cancer

3a. Cancer Diagnosis/Treatment History. Has a member of the medical profession ever diagnosed or treated the person(s) to be insured for any type of cancer (except basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

3b. Cancer Leukemia/Lymphoma. If the answer to the Cancer Diagnosis/Treatment History question is yes, has a member of the medical profession diagnosed or treated that person(s) for Leukemia, Hodgkin's Disease, Lymphoma, or cancer with any lymph node involvement or metastasis?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

3c. Cancer Other. If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a member of the medical profession diagnosed or treated that person(s) for any other type of cancer (other than those listed in the Cancer Leukemia/Lymphoma question and/or basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Disability

4. Major Medical Condition History. In the last 2 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?

- Cancer (except basal cell carcinoma)
- Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)
- Chronic Fatigue Syndrome
- Counseling for alcohol or drug abuse
- Diabetes
- Emphysema
- Fibromyalgia
- Heart Disease/Disorder
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lung Disease/Disorder
- Lupus
- Optic Neuritis
- Pancreas Disease
- Parkinson's Disease
- Paralysis
- Rheumatoid Arthritis
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation

Employee ☐ Yes ☐ No

Answer for the following: Disability

5. Back/Asthma History. In the last 2 years, has the person(s) to be insured had any disease of, been impaired by, or received treatment from a member of the medical profession for, the following (other than minor illness)?

- Any disorder of the back or neck
- Asthma

Employee ☐ Yes ☐ No

Answer for the following: Cancer w/Intensive Care Option

6. Heart/Stroke History. In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?

- Any artery disease
- Any abnormality of the heart
- Heart attack
- Heart condition
- Heart trouble
- Stroke or transient ischemic attack (TIA)

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Disability

7. Advised Medical Procedure History. In the last 5 years, has a member of the medical profession advised or recommended that the person(s) to be insured have any medical or surgical procedures (including organ transplant), which have not yet been performed?

Employee ☐ Yes ☐ No

Group Enrollment and Evidence of Insurability Form

Answer for the following: Cancer

9. Specified Disease History. Has a member of the medical profession ever diagnosed or treated the person(s) to be insured for any of the following?

Employee	☐ Yes	☐ No
Spouse	☐ Yes	☐ No
Child(ren)	☐ Yes	☐ No

- Addison's Disease
- Brucellosis
- Cerebrospinal meningitis
- Cystic Fibrosis
- Encephalitis
- Hansen's Disease
- Hepatitis (Chronic B, Chronic C with liver failure, or hepatoma)
- Legionnaires' Disease
- Lou Gehrig's Disease (ALS)
- Lyme Disease
- Muscular Dystrophy
- Multiple Sclerosis
- Myasthenia Gravis
- Osteomyelitis
- Primary Biliary Cirrhosis
- Primary Sclerosing Cholangitis
- Reye's Syndrome
- Rocky Mountain Spotted Fever
- Sickle Cell Anemia
- Systemic Lupus Erythematosus
- Tetanus
- Thalassemia
- Tuberculosis
- Tularemia
- Typhoid Fever

Answer for the following: Disability

10. Pregnant/Fertility Treatment. Is the person(s) to be insured currently pregnant or undergoing fertility treatment? **Employee** ☐ Yes ☐ No

Provide height and weight.

11. Employee for the following: Disability **Height:** _______ ft. _______ in **Weight:** _______ lbs.

Answer for the following: All products

12. Required Health History. 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. The undersigned producer and I certify that I have read or had read to me this completed form and understand that any misstatement or misrepresentation in this form may result in loss of coverage. I represent that statements and answers given on this form 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 Insurance Company 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 form may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION (EMPLOYEE). 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 CRITICAL ILLNESS)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, or MIB, Inc., that has records or knowledge of 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 understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits. 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 minor dependent for 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.

Employee Signature ____________ City/State ____________ Date Signed ____________

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.

Soliciting Producer Signature ____________ Soliciting Producer Name Printed ____________

Employee Name __________ Account No. V8582

Group Enrollment and Evidence of Insurability Form

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer			Soliciting Producer		
Lona Bishop	**5K0B0**	**50**	**Digital Insurance**	**5KYH0**	**50**