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 Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union **McCoy Federal Credit Union** / 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
		Employee			
		Spouse			

Premium/Billing Mode ☒ Bi-weekly Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	24265		**FL**

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE

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

Accident (GVAP1) (On and Off the Job Accident) ☐ Yes ☐ No	Base Units 2	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Bi-weekly Premium $_____	**Home Office Use Only**
☒ Benefit Enhancement Rider Units 2					

Cancer/Specified Disease (GVCP2) ☐ Yes ☐ No	Plan 1	☐ Employee Only ☐ Family	Section 125 ☒ Yes ☐ No	Total Bi-weekly Premium $_____	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☒ Cancer Screening Option
Units ☐ **Low Plan**	1	2	1	1	4
☐ **High Plan**	2	4	1	1	4

Hospital Indemnity (GVSP1) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Bi-weekly Premium $_____	**Home Office Use Only**

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	☒ Prescription Drug Option
Units ☐ **Low Plan**	1	1	1	N/A
☐ **Medium Plan**	2	1	1	N/A
☐ **High Plan**	2	1	1	2

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 & Hospital Indemnity	**1.** Is any person to be insured 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 in Question 10 below.				
	Underwriting Questions for Life and Late Enrollment	**EE**	**SP**	**CH**
Cancer & Hospital Indemnity	**2.** Has any person to be insured, in the last 10 years, tested positive for exposure to the HIV infection or been diagnosed by a licensed health care practitioner as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Hospital Indemnity	**3.** Has any person to be insured, in the last year, been diagnosed by a licensed health care practitioner with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer & Hospital Indemnity	**4a.** Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any type of cancer, other than basal cell carcinoma?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	4b. If the answer to 4a. is yes, has that person(s) been diagnosed with or treated by a licensed health care practitioner for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	4c. If the answer to 4a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a licensed health care practitioner for any other type of cancer (other than those listed in 4b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Hospital Indemnity	**5.** Has any person to be insured, in the last 5 years, been diagnosed with or treated by a licensed health care practitioner for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart, or any artery disease?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Hospital Indemnity	**6.** 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 licensed health care practitioner, but not done at this time?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer	**7.** Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any of the following? • Addison's Disease • Brucellosis • Cerebrospinal meningitis • Cystic Fibrosis • Encephalitis • Hansen's Disease • Hepatitis (Chronic B or Chronic C with liver failure or hepatoma) • Legionnaire's 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 • Tuberculosis • Thallasemia • Tularemia • Typhoid Fever	☐Y ☐N	☐Y ☐N	☐Y ☐N
Hospital Indemnity	**8.** Is any person to be insured currently pregnant or undergoing fertility treatment?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Hospital Indemnity	**9.** Provide Height and Weight of Proposed Insured: Height: Weight:			
Required Health History	**10.** Provide health history for any "Yes" answers to the Underwriting questions (except question 2). Include physician's (or other licensed health care practitioners) 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 contained in this application are representations, not warranties and 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 agent (producer) 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.

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Signature of Owner, if other than Insured N/A

Signature of Employee/Payor, if not Insured or Owner N/A

Agent’s (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 Florida Agent (Producer) _____

Print Soliciting Agent (Producer) Name _____

Florida Agent License Number _____

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

Agent (Producer) Name	Agent (Producer) Number	National Agent (Producer) Number (NPN)	Percentage Credit
Servicing Agent (Producer): Renaissance Benefit Advisors	**1P0F0**		%
Soliciting Agent (Producer):			%
			%
			%
			%

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1776 AMERICAN HERITAGE LIFE DRIVE
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ELECTRONIC DELIVERY ELECTION (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance (certificate(s)) and/or my policy(ies), including all documents accompanying my certificate(s) and/or my policies. I also elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) and/or my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will be mailed instructions at the last provided residence address and/or email address on how to receive my certificate(s), policy(ies) and 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 9.0 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) and/or my policy(ies), 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.

I understand and agree that this election is effective for all certificate(s) and/or policy(ies) applied for and/or enrolled in on the date signed as noted below.

Proposed Insured Name: _____ Date Signed: _____

Owner Printed Name (if other than Insured): _____ Account Number (if applicable): 24265

Owner Social Security Number: _____ Account Name (if applicable): Mccoy Federal Credit Union

Owner Signature: _____

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).

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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 only when you are treated for one of the specific diseases or health conditions listed in the policy. 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
- hospice
- 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).

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