



BE WELL. BE SMART. BE PROTECTED

Allstate at Work®

group voluntary critical illness insurance

My Lifeline

When you think about your family have any of them experienced a heart attack, stroke, kidney failure, or life-threatening cancer? If you answered yes, then you understand the emotional and financial impact a critical illness can have on your hard-earned savings.

Today, advancements in medical technology can mean an increase in the chances of surviving a critical illness or living with a critical illness for months, perhaps even years. Are you or your family financially prepared in the event you survive a critical illness?

Just think about the chances of becoming critically ill or living with a critical illness and consider these statistics:

- Stroke is the leading cause of serious, long-term disability in the United States. ¹
- At age 40, the lifetime risk of developing Heart Failure for both men and women is one in five. ¹
- 13,200,000 victims of angina, heart attack, and other forms of coronary heart disease are still living. ²
- About 76% of all cancers are diagnosed in persons 55 and older. ³
- Men have a 1 in 2 lifetime risk of developing cancer; for women the risk is a little more than 1 in 3. ³

The good news is that Allstate Workplace Division's Group Voluntary Critical Illness product pays a lump sum benefit to each covered person at the time of diagnosis. This benefit can be used to help meet expenses which are not normally covered under traditional health insurance. Which means you and your family can concentrate on getting well without worrying about having enough money to cover the bills.

If you were diagnosed with a critical illness today, would your finances be there for tomorrow?

1. *Heart Disease and Stroke Statistics Update*, American Heart Association, 2006.
2. American Heart Association Website, www.americanheart.org.
3. *Cancer Facts & Figures*, American Cancer Society, 2005.

L & K Insurance Center

800-622-0057
www.hveb.com
email: info@hveb.com



AWD12872X

Group Voluntary Critical Illness Benefits

What You Get

- Your choice of a \$5,000 or \$10,000 basic benefit amount.
- The maximum amount payable by AWD for Categories 1, 2 and 3 is 100% of the basic benefit amount.
- Benefits paid directly to you unless you assign them to someone else.
- Individual, spouse, and child(ren) coverage is available. Spouse and child(ren) basic benefit amount is 50% of the primary insured.
- Portable coverage. If you leave the company or employment is terminated, you can continue coverage as long as premiums are paid to Allstate Workplace Division.
- Coverage that does not replace your other group medical benefits. Instead, it is designed to supplement.

Group critical illness coverage only provides benefits as defined, or other optional benefits described in your certificate. The amount paid for each illness listed in Categories 1, 2 and 3 (except Coronary Artery By-Pass Surgery and Alzheimer's Disease) is at 100% of the basic benefit amount. Coronary Artery By-Pass Surgery, Alzheimer's Disease and Carinoma in Situ are at 25% of the basic benefit amount. No more than \$5,000 is payable in each category for the Low Option and \$10,000 for the High Option.

Benefit Category 1 - Group Critical Illness Coverage		Low Option	High Option
Heart Attack - The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. Diagnosis must be based on both new electrocardiographic changes; and elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
Heart Transplant - The surgical transplantation of the heart from a patient who died and whose heart was intact and capable of functioning in the recipient. The transplanted organ must come from a human donor.	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
Stroke - Death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit. Transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded.	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
Coronary Artery By-Pass Surgery - Undergoing a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for bypass surgery will be required. The following procedures are not considered by-pass surgery: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.	Insured	\$1,250	\$2,500
	Spouse & Child(ren)	\$625	\$1,250
Benefit Category 2 - Group Critical Illness Coverage		Low Option	High Option
Major Organ Transplant (other than heart) - The surgical transplantation of a lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
End Stage Renal Failure - Failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis or a renal transplant.	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
Paralysis (not as a result of a stroke) - Complete and permanent loss of use of two or more limbs. Paralysis as a result of stroke is excluded.	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
Alzheimer's Disease - A clinically established diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, 3 or more of the following activities of daily living: bathing; or dressing; or toileting; or eating; or taking medication.	Insured	\$1,250	\$2,500
	Spouse & Child(ren)	\$625	\$1,250

Low Option and High Option Premiums	Weekly	Issue Age: 18-35	
The Low Option package and premiums consist of: Category 1 and Category 2 Group Voluntary Critical Illness benefits; Optional/Additional Category 3 Group Critical Illness Cancer Coverage; Optional/Additional Wellness Benefit (2 units), and Optional/Additional Recurrence Benefit.	Non-Tobacco	Low Option	High Option
	Employee Only	\$1.08	\$1.69
	Employee and Spouse	\$1.66	\$2.56
	Employee and Child(ren)	\$1.13	\$1.80
	Family	\$1.73	\$2.69
	Tobacco*	Low Option	High Option
Employee Only	\$1.58	\$2.70	
Employee and Spouse	\$2.41	\$4.06	
Employee and Child(ren)	\$1.64	\$2.82	
Family	\$2.48	\$4.19	

Issue ages: 18 and over for full or regular time and 19 and over for part time

*Any person to be insured who has smoked cigarettes in the last 12 months

Rates are based on the issue age of the employee and the tobacco status of the proposed covered person.

Benefit Category 3 - Optional/Additional Group Critical Illness Cancer Coverage		Low Option	High Option
<p>Invasive Cancer - AWD pays this benefit if a covered person is diagnosed with a new form or type of invasive cancer, which means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes Leukemia and Lymphoma. This is subject to all of the following: clear and definitive diagnosis by either a pathological or clinical method; and the date of diagnosis is after the effective date of coverage; and the date of diagnosis is while this optional benefit is in force; and the illness is not excluded by name or specific description in the certificate.</p>	Insured	\$5,000	\$10,000
	Spouse & Child(ren)	\$2,500	\$5,000
<p>Carcinoma in Situ - AWD pays this benefit if a covered person is diagnosed with a new form or type of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer in Situ includes: early prostate cancer diagnosed as stage A or equivalent staging; and melanoma not invading the dermis. Carcinoma in Situ does not include: other skin malignancies; or pre-malignant lesions (such as intraepithelial neoplasia); or benign tumors or polyps. This is subject to all of the following: clear and definitive diagnosis by either a pathological or clinical method; and the date of diagnosis is after the effective date of coverage; and the date of diagnosis is while this optional benefit is in force; and the illness is not excluded by name or specific description in the certificate.</p>	Insured	\$1,250	\$2,500
	Spouse & Child(ren)	\$625	\$1,250

Optional/Additional Benefits	Low Option	High Option
<p>Wellness Benefit (Cancer Screenings and Heart Screenings) - AWD pays \$25 for each unit of coverage, up to a maximum of 4 units, each calendar year per covered person, for one of the following cancer screening tests or heart screening tests performed while not hospital confined: Bone Marrow Testing; CA15-3 (blood test for breast cancer); CA125 (blood test for ovarian cancer); CEA (blood test for colon cancer); chest X-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; mammography, including breast ultrasound; Pap Smear, including ThinPrep Pap Test; PSA (blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); biopsy for skin cancer; stress test on bike or treadmill; electrocardiogram (EKG); carotid doppler; echocardiogram; lipid panel (total cholesterol count); and blood test for triglycerides. There is no limit to the number of years a covered person can receive cancer screening tests. This benefit is paid regardless of the result of the test(s) and is limited to one test per calendar year per covered person.</p>	\$50 2 units	\$50 2 units
<p>Recurrence Benefit - AWD pays this benefit if a covered person is diagnosed more than once with the same specified critical illness listed in category 1 or 2 for which a benefit was previously paid if: there is more than 18 months between each diagnosis; and treatment was not received during that 18 month period (for purposes of the preceding statement, treatment does not include medications and follow-up visits to your physician); and the subsequent date of diagnosis is while coverage is in force; and the specified critical illness is not excluded by name or specific description in the certificate. • AWD will pay an amount equal to 25% of the specified critical illness basic benefit amount previously paid for that specified critical illness. AWD will pay no more than one recurrence benefit per previously paid specified critical illness under category 1 and 2.</p>	25% of previously paid Category 1 or 2 benefits	25% of previously paid Category 1 or 2 benefits

Example of how benefits are paid under the \$5,000 Low Option

Benefit	Amount Payable
If you have	
■ Coronary Artery By-Pass Surgery then -	■ Coronary Artery By-Pass Surgery at 25% = \$1,250
■ a Heart Attack then -	■ Heart Attack at 75% = \$3,750 (Since By-Pass Surgery paid)
■ Alzheimer’s Disease then -	■ Alzheimer’s at 25% = \$1,250
■ a Cancer Screening Test then -	■ CEA (blood test for colon cancer) = \$50 (2 units)
■ Invasive Cancer then -	■ Invasive Cancer at 100% = \$5,000
■ a second Heart Attack 2 years later	■ Heart Attack at 25% of previously paid benefit (because Recurrence Benefit is included) = \$937.50

After 100% of the basic benefit amount of the certificate has been paid within a category (Category 1, Category 2, or Category 3), AWD does not pay any more benefits for any illness associated with that category. Once the covered person has exhausted all basic benefit maximums in Categories 1, 2, and 3 and the Optional/Additional Recurrence Benefit, coverage is terminated.

Total Category 1, Category 2, Category 3, Wellness and Recurrence Benefits paid = \$12,237.50
The covered person is still eligible for up to \$3,750 under Category 2 benefits.

Issue Age: 36-49		Issue Age: 50-59		Issue Age: 60-64		Issue Age: 65-69		Issue Age: 70+	
Low Option	High Option	Low Option	High Option	Low Option	High Option	Low Option	High Option	Low Option	High Option
\$2.16	\$3.86	\$4.31	\$8.15	\$6.57	\$12.67	\$8.12	\$15.77	\$9.49	\$18.51
\$3.27	\$5.79	\$6.43	\$12.11	\$9.79	\$18.83	\$12.09	\$23.42	\$14.09	\$27.43
\$2.23	\$4.00	\$4.37	\$8.27	\$6.64	\$12.81	\$8.18	\$15.90	\$9.55	\$18.63
\$3.33	\$5.90	\$6.50	\$12.25	\$9.85	\$18.94	\$12.16	\$23.56	\$14.16	\$27.57
Low Option	High Option	Low Option	High Option	Low Option	High Option	Low Option	High Option	Low Option	High Option
\$3.81	\$7.16	\$7.95	\$15.44	\$10.83	\$21.19	\$12.12	\$23.77	\$13.13	\$25.80
\$5.71	\$10.66	\$11.84	\$22.93	\$16.09	\$31.43	\$17.99	\$35.23	\$19.51	\$38.26
\$3.87	\$7.27	\$8.02	\$15.58	\$10.88	\$21.30	\$12.18	\$23.89	\$13.20	\$25.94
\$5.76	\$10.77	\$11.90	\$23.05	\$16.15	\$31.54	\$18.05	\$35.35	\$19.58	\$38.39

Eligibility - All full-time and regular time employees age 18 or over and part-time employees age 19 or over who are actively at work at the time of application and the effective date of coverage.

Dependent Coverage - Family members who are eligible for coverage are: your spouse (or domestic partner); your unmarried children including adopted children, step children (child(ren) of domestic partner), or legal ward who is under 22 years of age, or under 26 years of age and full-time students at an educational institution of higher learning beyond high school. Children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment or evidence of insurability form. Children born to you or your spouse while Individual and Child(ren) coverage or Family coverage is in force will be eligible for coverage. Coverage begins at the moment of birth.

Portability Privilege - AWD will provide Group Voluntary Critical Illness insurance portability coverage, subject to the following provisions. Coverage will not be available to an employee or member unless: coverage under the policy terminates as stated in the "Termination of Coverage" provision; and we receive a written request and payment of the first premiums for the portability coverage no later than 30 days after such termination; and the request is made on a form we furnish or approve for that purpose. Specific criteria for coverage, premiums, grace period and termination of insurance provisions are included with this privilege; refer to the policy or certificate for complete details. ***This option is not available to an employee or member if they failed to make the required monthly premium payments.***

Continuation of Coverage (COBRA) - Since this plan is employer sponsored, it is subject to the same federal COBRA continuation requirements that apply to medical plans. In general, this allows you to continue insurance under the policy for 18 months after your employment terminates. If your dependent should lose coverage due to your death, divorce, or attainment of the limiting age for eligibility of dependents, the coverage may be continued for up to 36 months. If the policy is terminated by your employer before the end of the COBRA continuation period, you are entitled to continue coverage under the Portability Provision.

Termination of Coverage - Coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which any required premium payments were made; or the last day you are in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence, or Family and Medical Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible; or the date you have received the maximum total percentage of the basic benefit amount for each critical illness category, including the Optional Recurrence Benefit, if applicable.

Pre-Existing Condition Limitation - AWD does not pay for any loss due to a pre-existing condition, as defined, during the 12 month period beginning on the date you became an insured. A pre-existing condition is a disease or physical condition for which symptoms existed within the 12 month period prior to the effective date of coverage; or medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not yet been made.

Exclusions & Limitations - AWD does not pay benefits for an illness due to, or resulting from, (directly or indirectly): any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or intentionally self-inflicted injuries; or injury incurred while engaging in an illegal occupation or committing or attempting to commit a felony; or attempted suicide, while sane or insane; or any loss sustained or contracted in consequence of the insured being under the influence of alcohol, narcotics or any controlled substance or drug unless administered upon the advice of a physician; or participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.



This brochure is for use in the Hy-Vee enrollment which is situated in Iowa.

Group Voluntary Critical Illness benefits provided by policy form GVCIP1, or state variations thereof. This guide highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the policyholder (employer) and the insurance company. **This is a limited benefit Critical Illness Policy with optional benefits, which provides stated benefits for specified illnesses or other benefits that may be added.** The policy does not provide benefits for any other sickness or condition. The policy and optional benefits are not a Medicare Supplement Policy. Subject to COBRA continuation of coverage. Underwritten by American Heritage Life Insurance Company.

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www.allstate.com or allstateatwork.com



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224*

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM
Group Voluntary Critical Illness

This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.) First M.I.		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)		CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION Hy-Vee, Inc.		EMPLOYEE ID NUMBER
DATE HIRED (MM/DD/YEAR)	OCCUPATION	PLANT OR DIVISION		
Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", indicate type of change: _____				
Date of change _____ Current Certificate Number _____				
Do you currently have an individual Critical Illness product with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please enter the Policy Number _____				
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter effective date of termination _____				

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Dependent's Name(s) (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

SELECTION OF COVERAGE SECTION

Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> My Lifeline	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	Home Office Use Only SET ID _____
Basic Benefit Amount: <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000		Critical Illness Cancer Option <input type="checkbox"/>	Recurrence Option <input type="checkbox"/>	Wellness Option <input type="checkbox"/> Units <u> 2 </u>	
If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.					
Has any person to be insured used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, who and what type? _____					

Premium/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input checked="" type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Other	Case Number	Producer/ Agent Number	Percentage Credit
Date of First Deduction _____	Employee ID		
<input checked="" type="checkbox"/> Cash With Application _____	Situs State IA		

*Please mail to: **Hy-Vee Elective Benefits**
P.O. Box 737
Chariton, IA 50049

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected.)

Non-Medical Questionnaire					
1. Is the proposed insured actively at work now and has he/she 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Level 1 - Evidence of Insurability					
If any of the questions below are answered "yes", please list the required health history on the next page.					
2. 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 has ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
3a. Has any person to be insured in the last 2 years had, been treated for, or been told by a member of the medical profession that he/she has: diabetes; emphysema; asthma; epilepsy; hepatitis; mental or nervous illness; any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs, pancreas or back (including neck); or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
b. Is any person to be insured now being treated for, or ever been treated 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
c. Has any person to be insured been diagnosed with hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
d. If the answer to 3c is yes, in the last year has he/she had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
e. Has any person to be insured in the last 2 years been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
f. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
g. Has any person to be insured received any advice, treatment or consultation for Alzheimer's Disease, dementia, senility or organic brain syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Cancer: Evidence of Insurability, if Cancer Option selected					
4. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer (except basal cell skin cancer) or any malignancy which includes: carcinoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Level 2 - Additional Evidence of Insurability, if required					
5. Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Are any persons to be insured currently taking any prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
7. In the past 5 years has any person to be insured received medical advice, sought treatment or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this Evidence of Insurability form?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
8. Please indicate height and weight	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Employee</td> <td style="width: 50%; border: none;">Spouse</td> </tr> <tr> <td style="border: none;">Height: Weight:</td> <td style="border: none;">Height: Weight:</td> </tr> </table>	Employee	Spouse	Height: Weight:	Height: Weight:
Employee	Spouse				
Height: Weight:	Height: Weight:				
Level 3 - Additional Evidence of Insurability, if required					
9. Please indicate the names and addresses of all physicians for each person to be insured; use the space provided on page 3 for additional explanations.					

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

REQUIRED HEALTH HISTORY

List physician's name, address and telephone number

Name	Nature of Illness/Injury or Medical Attention/Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic

Use this space for any additional explanation of questions 2-9 on page 2. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers contained on this form 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 American Heritage Life Insurance Company as an inducement to grant insurance, and I understand that American Heritage Life Insurance Company may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Enrollment and Evidence of Insurability Form. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this Enrollment and Evidence of Insurability 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 Insurance Company, it's subsidiaries or its reinsurers, any information. I acknowledge receipt of the Important Notice About Privacy. 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 Insurance Company 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 coverage(s) requested above. This signature also verifies the accuracy of the information on this Enrollment and Evidence of Insurability Form. 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)

Dependent's Signature _____ Signed at _____ Date Signed _____
(Required for Spouse or Child over 18) (City and State)

IMPORTANT NOTICE ABOUT PRIVACY:

In processing your application, an investigative report may be made. Information is obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

GCI-IN