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

Allstate. BENEFITS

Group Voluntary Cancer (GVCP2) Evidence of Insurability Form

Remarks	*AHL home office use only*

General Information

All references to spouse include domestic partner relationships.

Employee Name *(Last, First, M.I.)*	Birth Date	Social Security No.

Eligibility Question

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

Employee answer for the following: Cancer

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 for Life Coverage and Late Enrollment Health Coverage

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

1. **AIDS History.** In the last 5 years, has the person(s) to be insured 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?

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

Answer for the following: Cancer

2a. **Cancer Diagnosis/Treatment History.** Has a licensed health care practitioner 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

2b. **Cancer Leukemia/Lymphoma.** If the answer to the Cancer Diagnosis/Treatment History question is yes, has a licensed health care practitioner 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

2c. **Cancer Other.** If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a licensed health care practitioner 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: Cancer

3. **Specified Disease History.** Has a licensed health care practitioner ever diagnosed or treated the person(s) to be insured for any of the following?

- 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

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

Employee Name _____ Account No. _____

Social Security Number _____

Group Voluntary Cancer (GVCP2) Evidence of Insurability Form

Answer for the following: All products

4. **Required Health History.** Provide health history for any yes answers to the underwriting questions (except questions about AIDS). Include physician's (or other licensed health care practitioners') name, address and telephone number:

REPRESENTATION. 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 contained in this form 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, AHL 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 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.

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.

Employee Signature	City/State	Date Signed