AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida

Allstate.

Workplace Division

REQUEST FOR GROUP INSURANCE

- ☐ AHLminimedical®
- ☐ Heritage Choice Dental
- ☐ Cancer/Specified Disease
- ☐ Accident
- ☐ Hospital Indemnity
- ☐ Critical Illness
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Term Life

For Home Office use only

Group/Case No. _____

_____

_____

Effective Date _____

Request is made to American Heritage Life Insurance Company (AHL) for the Insurance shown, by:

I. A. Group Name _____ (Legal Name)

B. Address _____ (Street) (City) (State) (Zip)

_____ (P.O. Box, if any) (City) (State) (Zip)

C. Contact Person(s) _____ ( ) _____ (Responsible Officer & Title) (Phone) _____ ( ) _____ (Administrative) (Phone)

D. Nature of Applicant's Business _____

E. Desired Effective Date _____

F. Affiliated Companies to be included:

Name	Location	Number of Employees	Is this Company a Wholly-owned Subsidiary of the above named Employer? YES	NO*
			☐	☐
			☐	☐
			☐	☐

If the "affiliate" is *not owned* by the company that will be the Group Policyholder, please provide the exact nature and full details of the relationship between these companies under Item XII, "Comments".

G. Is this a replacement of similar group coverage? ☐ Yes ☐ No If yes, termination date of prior plan _____

Name of Prior Insurance Company _____ *(attach copy of Certificate or SPD)*

H. Will the products selected be part of the policyholder's Employee Welfare Benefit Plan (ERISA)? ☐ Yes ☐ No
If yes, does the policyholder want us to include a Summary Plan Description in the employee's Certificates of Coverage? ☐ Yes ☐ No
If yes, complete the following information as it appears on the most recently filed Form 5500.
*If this Group has **NOT** previously had a similar Plan, insert the Plan No. and Name **AS IT WILL APPEAR** on the first form 5500 that the employer will file for this new plan.*
Er. Fed. I.D. No. _____ ERISA Plan No. _____ Plan Year: From _____ through _____ each year
Plan Name _____
If no, the Summary Plan Description will be the policyholder's responsibility.

II. A. There are _____ (total number) Employees who are eligible as follows: (Check the one that applies)
☐ Full-time Employees who work 30 or more hours per week ☐ Regular Part-time Employees who work 20 or more hours per week
☐ Full-time Employees who work 25 or more hours per week ☐ Other (explain): _____

B. Describe any class of Employees to be excluded: _____

C. Waiting Period is _____ (Month or Days). Upon completion of the Waiting Period, employees become eligible:
☐ First Day of the Calendar Month - or - ☐ Next Day If Waiting Period does not apply or is different for some classes, please explain: _____

D. Employees in the waiting period on the policy effective date will:
☐ Complete Waiting Period - or - ☐ Be eligible immediately.

E. Annual Enrollment Period (*Not applicable to Cancer, Accident, Critical Illness or Hospital Indemnity*) is:
☐ The Calendar Month before the Policy Anniversary Date - or - ☐ Other (explain) _____

F. Employees hired after the policy effective date will be allowed to enroll: ☐ within 31 days of eligibility - or - ☐ at the next Annual Enrollment Period.

III. AHLminimedical®: ☐ Yes ☐ No **Section 125:** ☐ Yes ☐ No

Check one: *INCLUDE COPY OF SOLD PLAN AND RATES	☐ PLAN 1*	☐ PLAN 2*	☐ PLAN 3*	☐ OTHER*

The *Employer* contributes $_____ or _____% towards each Employee's Total Monthly Premium.
The *Employer* contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

BUY UP OPTIONS
(Coverage Employee may add to Medical Expense Insurance)

☐ Life Insurance: (Amounts coincide with AHLminimedical® Plan selected above)	Plan 1	Plan 2	Plan 3	Other
Employee	$ 20,000	$ 20,000	$ 10,000	$ _____
Spouse or Child	$ 10,000	$ 10,000	$ 5,000	$ _____

Life amounts will be 75% of the amounts above for Insured Persons who are ages 65-69 and 50% for those who are age 70 and over.

☐ **Dental - Check one:** ☐ PLAN 1 (Standard) ☐ PLAN 2 ☐ PLAN 3 ☐ PLAN 4 ☐ PLAN 5

☐ **Short Term Disability:** Non-Occupational Coverage (off the job only)
Monthly Benefit: $650
Elimination Period: 7 Days Accident/ 7 Days Sickness
Maximum Payment Duration: 3 months

The *Employer* contributes $_____ or _____% towards the **Buy Up Options** for each Employee's Total Monthly Premium.
The *Employer* contributes $_____ or _____% towards the **Buy Up Options** for each Dependent Unit's Total Monthly Premium.

IV. Heritage Choice Dental Plan: ☐ Yes ☐ No **Section 125:** ☐ Yes ☐ No

Check one: ☐ PLAN 1 ☐ PLAN 2 ☐ PLAN 3 ☐ PLAN 4 ☐ PLAN 5

The *Employer* contributes $_____ or _____% towards each Employee's Total Monthly Premium.
The *Employer* contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

V. Cancer/Specified Disease: ☐ Yes ☐ No **Section 125:** ☐ Yes ☐ No

Check one: ☐ PLAN 1 ☐ PLAN 2 ☐ PLAN 3

BENEFITS (Select Units)	UNITS	OPTIONAL BENEFITS (Select Units)	UNITS
Hospital Benefits	_____	☐ Initial Diagnosis	_____
Radiation/Chemotherapy Benefits	_____	☐ Intensive Care	_____
Surgery/Related Benefits	_____	☐ Cancer Screening	_____
Miscellaneous Benefits	1		

The *Employer* contributes $_____ or _____% towards each Employee's Total Monthly Premium.
The *Employer* contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

VI. Accident: ☐ Yes ☐ No **Section 125:** ☐ Yes ☐ No

Base Units: _____ **Disability Rider Units:** EMPLOYEE _____ SPOUSE _____

Optional Disability Riders

☐ Off the Job Accident
☐ On and Off the Job Accident
☐ Off the Job Accident and Sickness
☐ On and Off the Job Accident and Sickness
☐ On and Off the Job Accident for Insured Spouse*
☐ On and Off the Job Accident and Sickness for Insured Spouse*

*** Available only when family coverage is selected and Insured Spouse has worked 25 hours per week for 3 consecutive months.**

The *Employer* contributes $_____ or _____% towards each Employee's Total Monthly Premium.
The *Employer* contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

VII. Hospital Indemnity: ☐ Yes ☐ No Section 125: ☐ Yes ☐ No

BENEFITS (Select Units)	UNITS	OPTIONAL BENEFITS (Select Units)	UNITS
Hospital Related	_____	☐ Diagnostic/Wellness Option	_____
Surgery/Inpatient Physician	_____	☐ Prescription Drug Option	_____
Outpatient Related	_____		

☐ Life Insurance Rider	UNITS _____	*Life amounts will be 75% of the amounts selected for Insured Persons who are ages 65-69 and 50% for those who are age 70 and over.*

☐ **Short Term Disability Rider:** Non-Occupational Coverage (off the job only)
Monthly Benefit: $650
Elimination Period: 7 Days Accident / 7 Days Sickness
Maximum Payment Duration: 3 months

The ***Employer*** contributes $_____ or _____% towards each Employee's Total Monthly Premium.
The ***Employer*** contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

BUY UP OPTION
(Coverage Employee may add to Hospital Indemnity Insurance)

☐ **Dental - Check one:** ☐ PLAN 1 ☐ PLAN 2 ☐ PLAN 3 ☐ PLAN 4 ☐ PLAN 5

The ***Employer*** contributes $_____ or _____% towards the **Buy Up Option** for each Employee's Total Monthly Premium.
The ***Employer*** contributes $_____ or _____% towards the **Buy Up Option** for each Dependent Unit's Total Monthly Premium.

VIII. Critical Illness: ☐ Yes ☐ No Section 125: ☐ Yes ☐ No

Basic Benefit Amount $ _____	**Check one:** ☐ My Lifeline ☐ New Generation
OPTIONAL BENEFITS ☐ Critical Illness Cancer Option ☐ Recurrence Option	**OPTIONAL BENEFITS** (Select Units) UNITS ☐ Wellness Option _____

The ***Employer*** contributes $_____ or _____% towards each Employee's Total Monthly Premium.
The ***Employer*** contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

IX. Short Term Disability: ☐ **Yes** ☐ **No** (Non-Occupational Coverage [off the job only]) **Section 125:** ☐ **Yes** ☐ **No**

1. **Monthly Benefit Amount:**
   ☐ The Employee may choose amounts in $100 units, subject to the following:
   - He/She must elect a monthly benefit of at least $400.
   - A maximum monthly benefit of ☐ $2,500; -or- ☐ $_____ (insert maximum from proposal, if it is not $2,500) applies. In addition, an employee's maximum monthly benefit may never exceed 60% of his/her Monthly Earnings, as defined in the policy; **- or -**

   ☐ The Employee's monthly benefit will be 60% of his/her Monthly Earnings, not to exceed:
   ☐ $2,500; -or- ☐ $_____

2. **Monthly Earnings** will not include: commissions, overtime, bonuses, or other extra compensation, unless specifically requested. If commissions must be included, please ☐ **CHECK HERE.** (Commissions will be averaged for the 12 month period just prior to the date of disability.)

3. **Elimination Period:**
   ☐ **7 Days** Accident / **7 Days** Sickness
   ☐ **14 Days** Accident / **14 Days** Sickness
   ☐ **30 Days** Accident / **30 Days** Sickness
   ☐ **0 Days** Accident / **7 Days** Sickness

4. **Maximum Payment Duration** will be: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

5. The ***Employer*** contributes $_____ or _____% towards each Employee's Total Monthly Premium.

X. Long Term Disability: ☐ **Yes** ☐ **No** (24-Hour Coverage with offset for Workers' Comp.) **Section 125:** ☐ **Yes** ☐ **No**

1. **Monthly Benefit Amount:**
   ☐ The Employee may choose amounts in $100 units, subject to the following:
   - He/She must elect a monthly benefit of at least $400.
   - A maximum monthly benefit of ☐ $6,000; -or- ☐ $_____ (insert maximum from proposal, if it is not $6,000) applies. In addition, an employee's maximum monthly benefit may never exceed 60% of his/her Monthly Earnings, as defined in the policy; **- or -**

   ☐ The Employee's monthly benefit will be 60% of his/her Monthly Earnings, not to exceed:
   ☐ $6,000; -or- ☐ $_____; **- or -**

   ☐ The Employee's monthly benefit will be 50% of his/her Monthly Earnings, not to exceed $_____. (*Please attach a copy of the proposal.*)

2. **Monthly Earnings** will not include: commissions, overtime, bonuses, or other extra compensation, unless specifically requested. If commissions must be included, please ☐ **CHECK HERE.** (Commissions will be averaged for the 12 month period just prior to the date of disability.)

3. **Elimination Period:** (Applicable to Disabilities due to both Accident and Sickness):
   ☐ 90 Days ☐ 180 Days ☐ 365 Days

4. **Benefit Duration** will be: ☐ To Normal Social Security Retirement Age* ☐ 2 Years* ☐ 5 Years*
   *Modified benefit duration may apply to disabilities beginning on or after age 60.

5. The ***Employer*** contributes $_____ or _____% towards each Employee's Total Monthly Premium.

XI. Life Insurance: ☐ Yes ☐ No **If yes, is Accidental Death & Dismemberment included?** ☐ Yes ☐ No

Employee Descriptions	A. Amounts of Life Insurance		B. Amounts of AD&D
	Employee		**Employee**
☐ All Eligible Employees - or - ☐ Other (describe): _____	☐ The amount elected by the employee (must be in even multiples of $10,000), subject to a minimum amount of $10,000 and a maximum amount equal to the lesser of: (a) $500,000; or (b) five times the Employee's Basic Annual Earnings.	-or- ☐ Three times the Employee's Basic Annual Earnings, subject to a minimum amount of $50,000 and a maximum amount of $500,000. -or- ☐ Other (describe): _____ _____	☐ An amount equal to the Amount of Life Insurance elected by the employee.
	Spouse		**Spouse**
	☐ The amount elected by the employee for his/her spouse (must be in even multiples of $10,000), subject to a minimum amount of $10,000 and a maximum amount equal to the lesser of: (a) $100,000; or (b) 50% of the amount of Voluntary Life Insurance in force on the Employee.	-or- ☐ Other (describe): _____ _____ _____ _____	☐ An amount equal to the Amount of Life Insurance elected by the employee for his/her spouse.
	Child(ren)**		**Child(ren)****
	☐ All of the following: 1 year & Over / 14 days to 1 year Plan A $ 10,000 / $ 1,000 Plan B $ 7,500 / $ 750 Plan C $ 5,000 / $ 500 Plan D $ 2,500 / $ 250	-or- ☐ Other (describe): _____ _____ _____ ** Children who are less than 14 days old are not eligible.	☐ An amount equal to the Amount of Life Insurance elected by the employee for his/her child(ren). ** Children who are less than 14 days old are not eligible.

PLEASE NOTE:

1. Evidence of insurability is required for Life Insurance amounts (and AD&D) in excess of the following guaranteed issue amounts:

	Employee	Spouse
UNDER AGE 60	$ 50,000	$ 20,000
AGES 60 - 69	$ 20,000	$ 10,000
AGE 70 OR OVER	$ 5,000	$ 2,500

☐ Check Here and *attach a copy of the proposal, if there is a higher* Guaranteed Issue *limit for this group.*

2. The amount of Life Insurance and full amount of Accidental Death and Dismemberment Insurance (if included in the plan) for persons age 70 and over reduce to the following percentages, based on the attainment of the ages shown below. The increments of amounts elected, minimum and maximum, are also reduced as indicated. These reduced amounts apply at the time of initial election and corresponding reductions are made on the Premium Due Date that comes on or next follows the date the insured Employee or Spouse attains the specified age.

		Maximum Amount		
Employee Or Spouse's Attained Age	Minimum Amount	Employee	Spouse	Purchase In Multiples Of:
AGE 70 BUT LESS THAN AGE 75	$ 6,500	$ 325,000	$ 65,000	$ 6,500
AGE 75 BUT LESS THAN AGE 80	$ 5,000	$ 250,000	$ 50,000	$ 5,000
AGE 80 AND OVER	$ 5,000	$ 175,000	$ 35,000	$ 3,500

3. If insurance amount is based on Basic Annual Earnings (BAE):
   (a) Life (and AD&D) multiples are rounded to the next higher $1,000. (*Attach proposal if different*)
   (b) the definition of BAE does not include bonuses, overtime, commissions and similar forms of compensation, unless approved in the proposal. (*Please attach proposal*)

4. The **Employer** contributes $_____ or _____% towards each Employee's Total Monthly Premium.

   The **Employer** contributes $_____ or _____% towards each Dependent Unit's Total Monthly Premium.

XII. Billing Information

Initial Payment of $ _____ accompanies this Request for Group Insurance. After initial payment is made, billing frequency will be set up as chosen below:

	Billing Frequency	Bills Per Year
Please select one:	☐ Monthly	12
	☐ Every 4 Weeks (28 days)	13

How do you want your bill delivered? ☐ U.S. Mail ☐ E-mail _____

XIII. Comments

ITEM #	SPECIAL REMARKS

IT IS UNDERSTOOD AND AGREED THAT the insurance requested herein will become effective on the date specified by American Heritage Life Insurance Company (AHL) only after this Request for Group Insurance is accepted and approved by AHL at its Home Office, and shall be subject to all terms and provisions of the Policy(ies) issued and any amendments, riders, and/or endorsements thereto. The Policy(ies) issued and any amendments, riders, and/or endorsements thereto, along with the final application, will constitute the entire contract.

Signed at _____ this _____ day of _____, 20 _____
(City; State)

_____
(Print Full Legal Name of Applicant)

By _____ _____
(Authorized Officer Signature) (Title)

Agent: _____ _____
(Print Name of Agent) (Agent's Signature)

Agent's License Number: _____

SERVICING AGENT#	AGENT NAME	PREMIUM SPLIT	%
AGENT#	AGENT NAME	PREMIUM SPLIT	%
AGENT#	AGENT NAME	PREMIUM SPLIT	%

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.	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION	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.? ☐ Yes ☐ No

If "Yes", indicate type of change: _____

Date of change _____ Current Certificate Number _____

Do you currently have an individual Critical Illness product with AHL? ☐ Yes ☐ No

If "Yes", please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ 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 ☐ Yes ☐ No	☐ My Lifeline ☐ New Generation	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	Home Office Use Only SET ID _____

Basic Benefit Amount $ _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.	Critical Illness Cancer Option ☐	Recurrence Option ☐	Wellness Option ☐ Units _____

Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No

If so, who and what type? _____

Premium/Billing Mode	Case Number	Producer/ Agent Number	Percentage Credit
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other	Employee ID		
Date of First Deduction _____	Situs State		
Cash With Application _____			

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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No
c. Has any person to be insured been diagnosed with hypertension or high blood pressure?	☐ Yes ☐ 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?	☐ Yes ☐ No
e. Has any person to be insured in the last 2 years been treated for or counseled for alcohol or drug abuse?	☐ Yes ☐ 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?	☐ Yes ☐ No
g. Has any person to be insured received any advice, treatment or consultation for Alzheimer's Disease, dementia, senility or organic brain syndrome?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No
6. Are any persons to be insured currently taking any prescribed medication?	☐ Yes ☐ 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?	☐ Yes ☐ No

8. Please indicate height and weight	Employee Height: Weight:	Spouse 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.

If any person proposed for coverage has received medical care or advice within the past 90 days for a disease or physical condition, they will not be covered for such disease or physical condition until they have been covered for one year under the policy. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received in the past 90 days.

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. FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. · 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 _____ (City and State) Date Signed _____

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

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

Allstate.
Workplace Division

CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our Customer Care Center at 1-800-348-4489 8:00 A.M. to 8:00 P.M. Eastern Standard Time.

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

INSTRUCTIONS FOR FILING WELLNESS CLAIMS

- To avoid delays in processing please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number(s) call **1-800-348-4489**.
- You may fax your claim to us at **1-972-510-1773**. Please be assured that your claim will receive our prompt attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- You may mail your claim to: **American Heritage Life Insurance Company**
  P.O. Box 43067
  Jacksonville, Florida 32203-3067
- Additional claim forms are available on our website at www.allstateatwork.com.

POLICYHOLDER / CERTIFICATEHOLDER

1. First Name: _____ Middle: _____ Last Name: _____

Policy Number(s): 1)_____ 2)_____

Social Security Number: _____ Date of Birth: ____/____/____ MO/DAY/YR ☐ Male ☐ Female

2. Home Number: (____)_____ **E-mail:** _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____

4. Date of Birth: ____/____/____ MO/DAY/YR Age: _____ Social Security Number: _____ ☐ Male ☐ Female

5. This person is your: _____ (ex: self, wife, son, etc.) Is he/she a full-time student? ☐ Yes ☐ No

If yes, please submit proof of student status.

WELLNESS EXAM

INSTRUCTIONS FOR FILING WELLNESS CLAIMS:

☐ Please attach the physician, clinic, or facility receipt showing the specific wellness exam performed and date it was provided. Thank You.

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL), its subsidiaries or its reinsurers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. 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 AHL in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company. (In **MAINE** – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: _____ Date: _____ ☐ Check here if address is new
Claimant

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone No:. (____)_____

NOTICE IN NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: 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.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate.
Workplace Division

ENROLLMENT FORM

Check appropriate box(es)

- ☐ **Heritage Choice Dental**
- ☐ **Critical Illness**
- ☐ **Cancer/Specified Disease**
- ☐ **Accident**
- ☐ **Hospital Indemnity**

For AHL Home Office use only

Notes

GENERAL INFORMATION SECTION

Please print with black ink (Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc)	First	M.I.	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)				CITY	STATE / ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER		DATE HIRED (MM/DD/YEAR)	
OCCUPATION	PLANT OR DIVISION			CURRENT EARNINGS $_____ (also check appropriate box)	
BENEFICIARY'S NAME (Last, First, M.I.)		RELATIONSHIP		☐ Hourly ☐ Weekly ☐ Monthly ☐ Bi-weekly (26) ☐ Semi-monthly (24) ☐ Annually	

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?

Critical Illness	☐ Yes ☐ No	**Hospital Indemnity**	☐ Yes ☐ No
Cancer/Specified Disease	☐ Yes ☐ No	**Heritage Choice Dental**	☐ Yes ☐ No
Accident	☐ Yes ☐ No		

If "yes", indicate type of change: _____

Date of change _____ Current Certificate Number _____

DEPENDENT COVERAGE SECTION

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

Abbreviations: Den-Dental Can-Cancer Acc-Accident Hosp-Hospital CI-Critical Illness

Choose Plans: Den	Can	Acc	Hosp	CI	Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee + Child ☐ Employee + Spouse ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes", please enter the date coverage effective_____	**AHL Home Office Use Only** SET ID **ACTIV** or **EMPLR** or _____ PLAN ID **P1NG1** **P1NG2** **P1NG3**

Critical Illness ☐ Yes ☐ No	☒ My Lifeline	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only** SET ID_____

Basic Benefit Amount $_____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.	Critical Illness Cancer Option ☐	Recurrence Option ☐	Wellness Option ☐ Units _____

Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No
If so, who and what type?_____

Do you currently have an individual Critical Illness product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number_____
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination_____

Cancer/Specified Disease ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option ☐	Intensive Care Option ☐	Cancer Screening Option ☐
Units				1			

Do you currently have an individual Cancer product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number_____
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination_____

Accident ☐ Yes ☐ No	Base Units _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Optional Disability Riders for Employee
- ☐ Off the Job Accident
- ☐ On and Off the Job Accident
- ☐ Off the Job Accident and Sickness
- ☐ On and Off the Job Accident and Sickness

Optional Disability Riders for Spouse
- ☐ On and Off the Job Accident for Insured Spouse*
- ☐ On and Off the Job Accident and Sickness for Insured Spouse*

*Available only when family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.

Disability Rider Units Employee _____ Spouse _____

Do you currently have an individual Accident product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number_____
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination_____

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Hospital Indemnity ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Employee+Child(ren) ☐ Employee+Spouse ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option ☐	Prescription Drug Option ☐	Disability Rider ☐	Life Rider ☐
Units							

Do you currently have an individual Hospital Indemnity product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number _____
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination _____

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other_____ Issue Date _____ Cash With Application _____	Case Number	Producer/ Agent Number	Percentage Credit
	Employee ID		
	Situs State		

ACCEPTANCE: I hereby request all coverage checked "yes" above for which I am or may become eligible under the group coverages issued by AHL. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage. **FRAUD NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed. · **WAIVER/DECLINATION:** I understand that if I refuse any coverage for which I am eligible (by checking "no" above), 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.

Date Signed _____ Employee's Signature _____

Allstate.
Workplace Division

CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our Customer Care Center at 1-800-348-4489 8:00 A.M. to 8:00 P.M. Eastern Standard Time

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

INSTRUCTIONS FOR FILING CANCER / SPECIFIED DISEASE / ICU / HEART / STROKE CLAIMS

- To avoid processing delays, please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number(s) call **1-800-348-4489.**
- You may **fax** your claim to us at **1-972-510-1773.** Please be assured that your claim will receive our immediate attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- You may mail your claim to: **American Heritage Life Insurance Company**
  P.O. Box 43067
  Jacksonville, Florida 32203-3067
- Additional claim forms are available on our website at www.allstateatwork.com.
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

POLICYHOLDER

Employer Name (Company): _____ Occupation: _____

1. Policyholder's Name: First: _____ Middle: _____ Last: _____

   E-mail: _____ **Policy Number:** _____

   Social Security Number: _____ Date of Birth: ___/___/___ (MO/DAY/YR) ☐ Male ☐ Female

2. Home Number: (___) _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____
4. Date of Birth: ___/___/___ (MO/DAY/YR) Age: _____ Social Security Number: _____ ☐ Male ☐ Female
5. This person is your: _____ (ex: self, wife, son, etc.) Is he/she a full-time student? ☐ Yes ☐ No
   If yes, please submit proof of student status.

INSTRUCTIONS FOR FILING CANCER, SPECIFIED DISEASE, INTENSIVE CARE, AND HEART / STROKE CLAIMS

CANCER CLAIMS:

- ☐ A pathology report diagnosing cancer **must** accompany your first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made by clinical information instead of pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.
- ☐ Include a copy of your itemized hospital billing if you were hospitalized.
- ☐ Have the doctor complete **Attending Physician's Statement** and attach an itemized billing showing the diagnosis, services provided and the actual charges made to you.
- ☐ Any other bills pertaining to this claim, such as anesthesia, chemotherapy or radiation treatments, ambulance, lodging, or travel, may be forwarded to this office.
- ☐ *Transportation and Lodging* - Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.

SPECIFIED DISEASE:

- ☐ The results of tissue specimen, culture(s) and/or titer(s) or other diagnostic studies, which initially diagnosed the specified disease, must accompany your first claim. Include a copy of your itemized hospital billing and **Attending Physician's Statement.**

HOSPITAL INCOME AND INTENSIVE CARE CLAIMS:

- ☐ Please send a copy of your hospital bill showing charges and number of days in the intensive care unit.
- ☐ If the hospital bill fails to give the diagnosis, **Attending Physician's Statement** must be completed by the doctor.
- ☐ A copy of the police report is required for all accidents investigated by any law enforcement agency.

HEART STROKE CLAIMS:

- ☐ Submit diagnostic test result showing a diagnosis of disease of the heart, heart attack or stroke.

INSTRUCTIONS FOR FILING TRANSPORTATION AND LODGING CLAIMS:
☐ Please attach receipts for lodging and transportation (common carrier).

TRANSPORTATION AND LODGING

Name of Patient: _____ Condition Treated: _____
Dates of Travel: _____ Dates of Lodging: _____
Home Address: _____ Location of Treatment: _____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

1. Diagnosis: _____
2. If condition is due to pregnancy, what is expected delivery date? Date ____/____/____ MO/DAY/YR
3. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR
4. When did patient first consult you for this condition? Date ____/____/____ MO/DAY/YR
5. Has patient ever had same or similar condition? (If "yes," state when and describe.) ☐ Yes ☐ No _____
6. Describe any other diseases or infirmity affecting present condition. _____
7. Nature of surgical or obstetrical procedure, if any (describe fully). _____
8. Is patient unable to perform job duties? ☐ Yes ☐ No If yes, from _____ through _____
9a. What specific job duties is patient unable to perform? _____
9b. Specific RESTRICTIONS (What the patient should not do and why). Please quantify in hours, weight, etc. _____
9c. Specific LIMITATIONS (What the patient cannot do and why). _____
10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? _____
11. Date patient last examined by you: _____ Frequency of visits: ☐ weekly ☐ monthly ☐ other _____
12. Is patient: ☐ ambulatory ☐ bed confined ☐ house confined ☐ other _____
13. If patient is hospitalized, give name and address of hospital.
    Hospital: _____ City: _____ State: _____
14a. Date admitted: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR
14b. When do you expect patient to resume partial duties? ____/____/____ MO/DAY/YR Full duties? ____/____/____ MO/DAY/YR
14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? ____/____/____ MO/DAY/YR
15. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
    If "yes," explain. _____
    Name and address of referring physician if any.
    Name: _____ Address: _____
    City: _____ State: _____ Zip _____
16. Have you completed paperwork for any other insurance company? ☐ Yes ☐ No Social Security Disability? ☐ Yes ☐ No

Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 3 for notice specific to your state.

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ MO/DAY/YR Phone: (___) _____
Street Address: _____
City/Town: _____
State/Province: _____ Zip Code: _____

ASSIGNMENT OF BENEFITS

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send benefits available to the name and address shown below:

Name _____ Address _____
Provider's Tax Identification Number _____ City _____ State _____ Zip _____
Relationship _____
Signature of Policy Owner _____ Date _____

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL), its subsidiaries or its reinsurers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. 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 AHL in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and insured's name in a written request to the company. (In MAINE – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: _____ Date: _____ ☐ Check here if address is new
Claimant

Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No:. (___) _____

NOTICE IN NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

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NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Texas Life Insurance Company®

A MetLife Company

POST OFFICE BOX 830, WACO, TEXAS 76703-0830

LIFE INSURANCE APPLICATION

FOR HOME OFFICE USE ONLY

Plan Name: PL110-plus PRFNG-NI-99

Policy Number:_____

1st Deduction Date:_____ Employer:_____

Proposed Insured(s)		Sex	Social Sec No.	BirthDate	Age[1]	Face Amt[2]	Premium
Employee Name	Hire Date						
Last: First: MI:		M/F					
Spouse Name	Occupation						
Last: First: MI:		M/F					
Children							
		M/F					
		M/F					
		M/F					
		M/F					

Total premium: $

Home Address
Street/P.O. Box:
City: State: Zip:
Personal E-mail Address:
Phone — Day: ( ) Evening: ( )

Add Riders	Employee	Spouse	Child
Accidental Death	N/A	N/A	N/A[3]
Waiver Premium	☐	☐	☐[3]
Child Term $10,000	☐	☐	N/A

Add Rider Premium to amounts above

Payroll is per: ☐ Week ☐ Bi-Week ☐ Semi-Month ☐ Month ☐ Skip_____

Beneficiary for: (Employee is beneficiary of spouse/child unless stated below). If contingent desired, state below.

Employee:_____ Relationship:_____

Spouse:_____ Relationship:_____

Children:_____ Relationship:_____

1. Will proposed coverage replace or change any existing insurance or annuity policy? ☐ Yes ☐ No If "Yes", identify and complete replacement form. Company:_____ Policy No:_____

2. During the last six months, has the proposed insured:	Employee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
a. Been actively at work on a full time basis, performing usual duties? If not, furnish details below.	☐	☐	☐	☐	N/A	
b. Been absent from work due to illness or medical treatment for a period of more than five consecutive working days? If so, furnish details below.	☐	☐	☐	☐	N/A	
c. Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment, or treatment for alcohol or drug abuse? If so, furnish details below.	☐	☐	☐	☐	☐	☐

QUES NO.	NAME	DETAILS TO QUESTION

Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). **Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.**

X_____ X_____ X_____

Employee (and policyowner) Signature | Spouse Signature if to be insured | Child age 18 or older if to be insured

X_____

Enroller/Agent Signature | Print Enroller/Agent Name | Agt No. | Date | City | State

(1) Age as of Issue Date. (2) or Face Amount purchased by premium shown, if less. (3) If age 17 and higher.

FORM: 04M003-PA

Texas Life Insurance Company®

A MetLife Company

POST OFFICE BOX 830, WACO, TEXAS 76703-0830

SUPPLEMENT TO APPLICATION

Supplement to Application from (Employee): _____

Employee Social Security: _____ Application Date: _____

	Employee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
3. Within the past five years, has any proposed insured:						
a. Consulted a physician, been observed at a hospital or clinic, or been advised to have a surgical operation?	☐	☐	☐	☐	☐	☐
b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study?	☐	☐	☐	☐	☐	☐
c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?	☐	☐	☐	☐	☐	☐
d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?	☐	☐	☐	☐	☐	☐
4. Within the past ten years, has any proposed insured had or been treated for:						
a. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?	☐	☐	☐	☐	☐	☐
b. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?	☐	☐	☐	☐	☐	☐
c. Cancer, tumor, diabetes, or disorder of the blood?	☐	☐	☐	☐	☐	☐
d. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?	☐	☐	☐	☐	☐	☐
5. Is any proposed insured taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.	☐	☐	☐	☐	☐	☐
6. Within the past 12 months, has any proposed insured smoked a cigarette or used tobacco in any form?	☐	☐	☐	☐	☐	☐

7. What is the height, weight, and birth state of each proposed insured?	First Name	Hgt.	Wgt.	Birth State

8. Personal physician for each proposed insured (if none, enter "None")

Proposed Insured	Physician	Address	City, State

9. Details, including date, diagnosis, type of treatment, and current condition

Ques No.	Proposed Insured	Details	Name, address and phone # of physician(s)

Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this Supplement to Application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). **Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in the application and this Supplement to Application remain correct and complete.**

X _____ X _____ X _____

Employee (and policyowner) Signature | Spouse Signature if to be insured | Child age 18 or older if to be insured

X _____ _____ _____ _____ _____

Enroller/Agent Signature | Print Enroller/Agent Name | Agt No. | Date | City | State

FORM: 04M004-PA

Texas Life Insurance Company®

A MetLife Company

AUTHORIZATION FORM

Authorization to Release Information

Two pages

AUTHORIZATION

For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any insurer; any consumer reporting agency; and MIB Group, Inc. (MIB) to give Texas Life Insurance Company ("Company") information about me or such child(ren) including:
  - personal information and data;
  - entire medical file for the last ten (10) years, including medical information, records and data (such as: office visits; out-patient treatment; hospitalization; drugs prescribed; medical test results: information about sexually transmitted diseases; and other similar information);
  - information related to alcohol and drug abuse and treatment;
  - information, records and data relating to Acquired Immune Deficiency Syndrome(AIDS) or AIDS related conditions, including Human Immuno-deficiency Virus (HIV) test results; and
  - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain consumer investigation; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data received that the Company receives pursuant to this Authorization will be used and maintained by the Company as described in the Company Consumer Privacy Notice, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to the Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2. This information may be redisclosed as provided in this Authorization.

Since 1901 | 900 WASHINGTON AVE | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830 | 800-283-9233 | 254-752-6521 | www.texaslife.com

- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at anytime by writing to the Company and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

SIGNATURES

(Parent or Guardian, if a proposed insured is under age 18, sign on line for proposed insured.)

_____ _____

Proposed Insured # 1 *Date:*

Print Name of Proposed Insured # 1 _____

_____ _____

Proposed Insured # 2 *Date:*

Print Name of Proposed Insured # 2 _____

_____ _____

Witness *Date:*

Texas Life Insurance Company®

A MetLife Company

REPLACEMENT FORM

Pennsylvania

Notice Regarding Replacement of Life Insurance and Annuities

Two pages

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

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After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Information on policy being replaced

Issuing Company:_____ Policy Number:_____

Applicant Signature:_____ Date:_____

Agent Signature:_____ Date:_____

Texas Life Insurance Company®

A MetLife Company

Agent Certification

REPLACEMENT OF INSURANCE

To the best of my knowledge the insurance applied for ☐ is ☐ is not to replace existing insurance or annuity.

PURPOSE OF INSURANCE

Texas Life encourages a thorough consideration of the applicant's insurable needs as they affect his/her broader financial objectives. Based upon my discussion with the applicant, he/she indicated that the insurance applied for is for one or more of the following needs (check all that apply):

☐ Burial/Final Expense ☐ Income Replacement ☐ Mortgage Cancellation

☐ Other:_____

USA PATRIOT ACT

I have confirmed the identity of the Applicant from the following photographic identification:

Check One

☐ Employer ID ☐ Driver's License ☐ Passport

☐ Other government-issued ID (Describe):_____

ID Number:_____ Issuing Entity:_____

Applicant's Citizenship: ☐ USA ☐ Other: country of legal residence:_____

AGENT STATEMENT

I hereby certify that I have: (a) completed the "Replacement of Insurance", "Purpose of Insurance" and "USA Patriot Act" sections above; (b) delivered to the Applicant Sales Brochure Series form 06M049mb-PA EXP-B-WP, the Privacy Notice, the Disclosure Notice For Accelerated Death Benefit Due to Terminal Condition, and the Pennsylvania Disclosure Statement; and, (c) presented only guaranteed policy benefits and costs.

X_____ _____

Enroller/Agent Signature Date

Also Complete Pennsylvania Disclosure Statement form 1068-R01/99

Form: 04M006-PA

PURCHASING POWER
The every day benefit

APPLICATION & AGREEMENT

BUSINESS INFORMATION

Employer Name: Company URL:

Address:

City: State: ZIP Code:

Plan Administrator: Phone: Email:

Secondary Contact: Phone: Email:

HR Sponsor: Phone: Email:

Is HR ☐ centralized ☐ decentralized

Payroll Contact: Phone: Email:

Is Payroll ☐ centralized ☐ decentralized

AP Contact: Phone: Email:

IT Contact: Phone: Email:

# of Locations: Fed ID #: NAICS Code: D&B #:

Years in business: Stock Ticker: Industry Description:

EMPLOYEE INFORMATION

Benefit Eligible Employee (BEE) definition: Hours/Week or Other

Total # of	2005	2004	2003
BEE's (as of 12/31):			
BEE Terminations:			

Approximate percentage of workforce? Full-Time: % Part-Time: %

Salaried: % Hourly: %

Anticipated workforce reductions > 10% in next 12 months? ☐ YES ☐ NO

FILE TRANSFERS / PAYROLL INFORMATION

Transmission of Eligibility, Deduction and Remittance Files to be performed through FTP (with PGP encryption) or HTTPS as the online portal

Number of Payroll Slots available for this program: ☐ 1 ☐ 2 ☐ 3

Will Deductions need to be broken out by Division: ☐ YES ☐ NO

Unique Employee Identifier: ☐ SSN ☐ Employee/Payroll ID (Employee ***MUST*** know EID if it is unique identifier!)

Payroll System / Payroll Processor:

Can the payroll system accommodate the following: ☐ Combined Deductions ☐ Missed Deductions ☐ Target Amounts

Pay Frequencies: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other

Do you have any employees who are not paid 12 mos/yr (i.e., school teachers): ☐ Yes ☐ No

If Yes, please describe the Pay Cycles (i.e., 9 month, 10 month)

Payments to be remitted via: ☐ EFT ☐ ACH ☐ Other

PLEASE ATTACH A COPY OF YOUR PAYROLL CALENDAR, WITH CUT-OFF DATES, FOR THE CURRENT YEAR

MARKETING

Open Enrollment Dates: March 15 – April 15 July 15 – August 15 November 15 – December 15

Available marketing communication channels? (please choose a minimum of 4)

☐Home Mailer[1] ☐Email ☐ Newsletter ☐ Flyers[2] ☐ Posters[2] ☐ Intranet ☐ Open Enrollment Packet ☐ Other

Do you currently offer a Computer Discount Program? ☐ YES ☐ NO

If Yes, Mfr's? ☐ Dell ☐ Lenovo (IBM) ☐ Gateway ☐ Other:

[1]Purchasing Power will manage and assume costs for production and distribution.
[2]Purchasing Power will supply materials and Employer will be responsible for distribution.

PURCHASING POWER
The every day benefit

AGREEMENT FOR PAYROLL DEDUCTION
COMPUTER PURCHASE PLAN
BETWEEN
PURCHASING POWER, LLC and EMPLOYER (as identified on page 1 of application)

Employer agrees to establish a voluntary employee computer purchase program (the "Program") under which its eligible employees ("Employees") may purchase computer bundles and related accessories from Purchasing Power, LLC (hereinafter referred to as PPLLC) PPLLC and make payments for their purchases by payroll deduction. Accordingly, Employer and PPLLC agree as follows:

1. Employer agrees to provide PPLLC with data concerning employee turnover in a format which will allow PPLLC to set reasonable participation criteria. All such data received from Employer shall be held in strict confidence and not revealed to anyone not involved in the underwriting process at PPLLC.

2. Employer agrees to provide PPLLC with reasonable opportunities to market the program to eligible Employees for the purpose of promoting, explaining and offering the Program to such Employees, which may include enrollment during open enrollment periods, direct mail to employees, and other means of communicating with employees. The precise means of communicating with Employees shall be agreed by PPLLC and Employer during the implementation process.

3. Employer agrees to honor and administer all requests from Employees ("Participant") for periodic payroll deductions for the payment of computer purchases as specified by Participant.

4. PPLLC agrees to submit to Employer periodic statements indicating the amount of payments to be deducted from each participant's payroll. Employer agrees to withhold deductions authorized by its Employee-Participants and to remit to PPLLC all payroll deductions accumulated on behalf of each Participant in the amounts indicated in their periodic statements furnished to Employer by PPLLC. All deductions will be remitted to PPLLC in accordance with the schedule established during the implementation process.. Deductions missed because of insufficient pay, leave of absence, or termination will be dealt with in accordance with applicable law. payroll system capabilities and policies established during the implementation process.

5. Employer and PPLLC may terminate the Program upon 60 days written notice to the non-terminating party, at the address shown below. Following such termination, PPLLC shall immediately stop accepting new orders from Employees and Employer agrees to continue processing deductions for those purchases made prior to termination of this Agreement.

6. If an Employee is terminated from his or her employment, Employer agrees to notify PPLLC of such termination as soon as reasonably practical.

7. Employer and PPLLC agree that Employer is not responsible for the payment of any Employee purchase after the termination of employment. However, Employer shall be responsible for any and all funds which were or should have been deducted from such Employee's payroll prior to the effective date of Employee's termination.

8. PPLLC agrees that all information, records and other material obtained by it in connection with the enrollment of Employees in the Program, including, without limitation, information and records concerning the Employees of Employer, shall be treated as the proprietary and confidential information of Employer, and PPLLC, its employees and officers will not disclose any such confidential and proprietary information to any other person without the express prior written consent of Employer, except as required by law or regulation.

9. Employer assumes no other responsibility except as stated above.

THIS AGREEMENT SHALL BE CONSTRUED AND SHALL BE ENFORCED IN ACCORDANCE WITH THE LAWS OF THE STATE OF GEORGIA.

Employer: _____

By: _____

Name: _____

Title: _____

Purchasing Power, LLC.

By: _____

Name: _____

Title: _____

Purchasing Power, LLC.
695 Pylant Street N.E.
Atlanta, Georgia 30306
(404)-609-5100

LIFE INSURANCE APPLICATION Employee: _____ SSN: ___-___-____

SECTION K: Acknowledgement and Certification / Agreement and Signature

PROPOSED OWNER'S STATEMENT: All statements and answers are complete and true to the best of my knowledge and belief. It is agreed that all such statements and answers shall be made a part of any insurance policy issued.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I UNDERSTAND THAT THE INSURANCE WILL BE EFFECTIVE ON THE POLICY EFFECTIVE DATE. I, the owner, acknowledge that I saw a Quotation of Potential Policy Values only, when I applied for my new policy. I know that a complete illustration conforming to the policy as issued will be provided no later than the policy delivery if required by law.

Agent's Statement:
I certify that a Quotation of Potential Policy Values only was used in connection with the sale of the policy applied for, and that I have explained to the applicant that a complete illustration conforming to the policy as issued will be produced and delivered with the policy.
I further certify that I have explained that any nonguaranteed elements of the policy are subject to change. I have made no statements that are inconsistent with the illustration, which will be delivered with the policy if required by law.

PAYROLL DEDUCTION AUTHORIZATION: I authorize my Employer to deduct from my paycheck each pay period such sums certified to my Employer by ReliaStar Life Insurance Company (ReliaStar), or it's affiliate, or their Administrator, as necessary to pay the premium due for my insurance policy(ies). I assign these sums to ReliaStar or their Administrator. This authorization will remain in effect until revoked by me in writing to my Employer. I authorize my Employer to make future changes in payroll deduction resulting from changes in my ReliaStar insurance coverage.

Signed at: *(City & State)*	On: *(Month, Day, Year)*	Signature of Proposed Insured Spouse:
Signature of Proposed Owner *(Employee)*:		Signature(s) of Proposed Insured Children age 18 and Older:
Signature of Parent or Guardian:		Agent's Name *(please print)*:
Agent's License Number:		Signature of Agent:
Remarks or Special Requests:		

Life Insurance Application

ING

ReliaStar Life Insurance Company
Home Office:
P.O. Box 20, Minneapolis, Minnesota 55440
Administrative Office:
P.O. Box 122, Minneapolis, Minnesota 55440-0122

Product Name _____

Offer: ☐ GI ☐ AGI ☐ CI ☐ ACI ☐ QI ☐ AQI

Home Office use only **Group Benefit Plan #** _____

Home Office use only **Policy #** _____

Section A. Employer and Billing Information

1. Employer: _____ 2. Pay Mode: _____
3. Employee ID #: _____ 4. Dept. #: _____ 5. Loc. #: _____
6. Proposed Policy Effective Date: _____

Section B. Employee/Owner Information

1. Employee's Name: _____ 2. Social Security #: ___-___-____
3. Address: _____
   City, State, ZIP: _____
4. Phone #: (___) _____ 5. Date of Hire: _____ 6. Annual Salary: $ _____
7. Are you actively at work? ☐ Yes ☐ No

Section C. Proposed Insured Information ☐ Employee ☐ Spouse ☐ Dependent

1. Name: _____ 2. ☐ Male ☐ Female
3. Birthdate: ___/___/___ 4. Age as of Policy Effective Date: _____
5. Has the proposed insured used tobacco in any form in the last 24 months (2 years)? ☐ Yes ☐ No

Section D. Proposed Insured Questions (Do not complete this Section if applying for Guaranteed Issue coverage only.)

1. Has the proposed insured ever been diagnosed and/or treated by a member of the medical profession for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)?	☐ Yes ☐ No
2. Has the proposed insured sought or received care or treatment at a hospital, nursing home or has confinement been recommended (excluding pregnancy), within 90 days immediately preceding the date of this application?	☐ Yes ☐ No

Section E. Coverage Information

☐ Option A ☐ Option B (Check one option for Universal Life otherwise leave blank)

Initial Face Amount $_____

Base Weekly Premium $_____
Excess $_____ (Applies to Universal Life only)

Riders*
☐ Waiver
☐ ABR or ☐ LTC or ☐ ADBR
☐ ADB Face Amount $_____
☐ CTR Number of Units _____
☐ FAIR $_____/Week
☐ LTR _____% Face Amount $_____
☐ Other Name _____
☐ Other Name _____
☐ Other Name _____

Total Weekly Premium $_____

*Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Accelerated Death Benefit Rider (ADBR); Children's Term Insurance Rider (CTR); Face Amount Increase Rider (FAIR); Long Term Care Rider (LTC); Level Term Rider (LTR); Waiver of Monthly Deduction Rider or Waiver of Premium Rider (Waiver).

Section F. Supplemental Questions (Do not complete this Section if applying for Guaranteed Issue coverage only.)

1. Height _____ ft. _____ in. Weight _____ lbs **Agent:** Does the height and weight exceed the maximum shown on the chart provided?	☐ Yes ☐ No
2. Has the proposed Insured been diagnosed with or been treated for: any cardiovascular disease or disorder (excluding high blood pressure and functional/innocent heart murmur), stroke, insulin or non-insulin dependent diabetes (excluding gestational diabetes during pregnancy only), cancer (excluding basal cell carcinoma of the skin and/or squamous cell carcinoma of skin) or benign brain tumors?	☐ Yes ☐ No
3. Has the proposed Insured ever been diagnosed or treated for disorder of the brain (excluding headaches and epilepsy), central nervous system disorder, paralysis, dementia, manic and/or major depression, psychosis or suicide attempt?	☐ Yes ☐ No
4. Has the proposed Insured ever been diagnosed or treated for chronic lung disease (excluding asthma), sleep apnea, organ transplant, rheumatoid arthritis, chronic blood disorder, or connective tissue disorder?	☐ Yes ☐ No
5. Has the proposed Insured ever been diagnosed or treated for kidney disease or renal failure, liver disease (excluding Hepatitis A), pancreatic disease, Crohn's disease, or ulcerative colitis?	☐ Yes ☐ No
6. Has the proposed Insured sought help or received counseling or treatment for alcohol or drug abuse and not remained substance free for 10 years?	☐ Yes ☐ No
7. In the last 2 years, has the proposed Insured been put on probation or convicted of a felony, Driving Under the Influence (DUI), Driving While Impaired (DWI), or had motor vehicle license revoked or suspended?	☐ Yes ☐ No
8. In the last 12 months, has the proposed Insured had a recurrent disability, been disabled, or is disabled now?	☐ Yes ☐ No

If you answered "Yes" to any of the above questions, give details below. Attach an additional sheet of paper if necessary.

Question #	Name, address and phone number of Physician/ Health Practitioner	Condition/Illness/Injury	Date of Treatment	Remaining Effects

Section G. Proposed Children's Term Insurance Rider Information (Complete this Section only if Children's Term Insurance Rider is elected.)

List all unmarried dependent children who have not attained age 25 on whom Children's Term Insurance is desired. The beneficiary of children's coverage is, in all cases, the Proposed Insured, shown in Section C.

Child's First, Middle, Last Name	Birth Date	Relationship	Gender M/F	Is the proposed Insured child hospitalized on the date of this application?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section H. Replacement Information

1. Do you have any existing policies or contracts? (If Yes, complete state Notice Regarding Replacement, if required.) Current Carrier _____	☐ Yes ☐ No
2. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If Yes, complete state-required replacement form and provide details.)	☐ Yes ☐ No
3. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If Yes, complete state-required replacement form and provide details.)	☐ Yes ☐ No
4. Is the insurance you are now applying for intended to replace any existing life insurance or annuity?	☐ Yes ☐ No
5. **Agent:** To the best of your knowledge, does this insurance replace any existing insurance or annuities?	☐ Yes ☐ No

Section I. Beneficiary Information (Any percentage must be a whole percentage and total 100%.)

Name: _____ ☐ Primary ☐ Contingent

Relationship: _____ Percentage: _____% Social Security ___-___-____

Address: _____

Name: _____ ☐ Primary ☐ Contingent

Relationship: _____ Percentage: _____% Social Security ___-___-____

Address: _____

If no beneficiary is designated, the proceeds will be paid to the owner, if living, otherwise to the owner's estate.

Additional Information: _____

Section J. Additional Health Question, Authorization and Acknowledgement for Medical Underwriting (Complete this Section only if applying for an amount requiring Medical Underwriting.)

In the past 5 years, has the proposed Insured consulted a health practitioner or other member of the medical profession, received surgical or medical care or taken prescribed medication for any condition (including current treatment), not already indicated on this application? (If you answer Yes, give details below. Attach an additional sheet of paper if necessary.)	☐ Yes ☐ No

Name, address and phone number, of physician/health practitioner	Condition/Illness/Injury	Date	Prognosis

The responses in this application are complete and true to the best of my knowledge and belief.
I understand that if the policy cannot be issued as applied for, any excess premiums collected will be refunded to the owner. **For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, Medical Information Bureau, Inc (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me, my spouse, or any of my children who are to be insured: and (b) any non-medical information as it applies to me, my spouse, or any of my children who are to be insured. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these same persons. I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to get any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations-42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life. I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states that new use of the information or why another party needs it. I know that I have a right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for two years from the date shown below. I acknowledge that I have been given ReliaStar Life's Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.**

Signed at: *(City & State)*	On: *(Month, Day, Year)*	Signature of Proposed Insured Spouse:
Signature of Proposed Owner *(Employee)*:		Signature(s) of Proposed Insured Children Age 18 and Older:
Signature of Parent or Guardian:		Agent's Name *(please print)*:
Agent's License Number:		Signature of Agent: