AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT AND EVIDENCE OF INSURABILITY APPLICATION FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks: **CUSTOM FORM**	This box for AHL Home Office use only

GENERAL INFORMATION

Employee's Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union **McCoy Federal Credit Union** / Date Hired	Occupation	Plant Or Division	
Primary Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		
Contingent Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use* (Critical Illness)
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Critical Illness. For Critical Illness, tobacco rating applies to all covered persons if either the employee or the employee's spouse answers "Yes" to Tobacco Use.)**

Are you applying for coverage or changing existing coverage due to a qualifying event?

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

If "Yes," check the qualifying event:

☐ Marriage ☐ Spouse/Dependent Child Death ☐ Newly Eligible
☐ Divorce ☐ Eligible/Ineligible Child ☐ Termination
☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Employee Death

Date of Qualifying Event _____ Current Certificate Number(s) _____

Do you currently have any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?
Accident ☐ Yes ☐ No Cancer ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

If you answered "Yes" to any of the coverages, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes," please enter effective date of termination _____

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

(McCoy Federal Credit Union)
(EOI L70PA)
(2016)

ENROLLMENT AND EVIDENCE OF INSURABILITY APPLICATION FORM

SELECTION OF COVERAGE

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

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

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

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

Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Bi-weekly Premium $ _____	**Home Office Use Only**

Basic Benefit Amount $10,000		
☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 2	☒ Cancer Critical Illness Option

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

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

ENROLLMENT AND EVIDENCE OF INSURABILITY APPLICATION FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

Eligibility Question			EE	SP	CH
Cancer, Critical Illness & Hospital Indemnity	**1.**	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?	☐Y ☐N	N/A	N/A
If any of the questions below are answered "yes," please list the required health history on page 4. *For Critical Illness, Underwriting Questions are not applicable to children.					
Underwriting Questions for Life Coverage and Late Enrollment Health Coverage			**EE**	**SP**	**CH**
Cancer, Critical Illness* & Hospital Indemnity	**2.**	Has any person to be insured, in the last 5 years, tested positive for exposure to the HIV infection or been diagnosed by a licensed health care practitioner as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness* & Hospital Indemnity	**3.**	Has any person to be insured, in the last year, been diagnosed by a licensed health care practitioner with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer, Critical Illness Cancer Option* & Hospital Indemnity	**4a.**	Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any type of cancer, other than basal cell carcinoma?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	4b.	If the answer to 4a. is yes, has that person(s) been diagnosed with or treated by a licensed health care practitioner for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	4c.	If the answer to 4a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a licensed health care practitioner for any other type of cancer (other than those listed in 4b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness	**5.**	Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a licensed health care practitioner for any of the following? • Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy) • Chronic Fatigue Syndrome • Diabetes • Emphysema • Fibromyalgia • Heart Disease • Kidney Disease/Disorder (including dialysis and/or chronic renal failure) • Liver Disease • Lung Disease • Lupus • Optic Neuritis • Parkinson's Disease • Paralysis • Rheumatoid Arthritis	☐Y ☐N	☐Y ☐N	N/A
Hospital Indemnity	**6.**	Has any person to be insured, in the last 5 years, been diagnosed with or treated by a licensed health care practitioner for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart, or any artery disease?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness* & Hospital Indemnity	**7.**	Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a licensed health care practitioner, but not done at this time?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Critical Illness Supplemental Benefits Option	**8.**	Has any person to be insured, in the last 5 years, been diagnosed with or received any advice, treatment or consultation by a licensed health care practitioner for any of the following? • Alzheimer's Disease, dementia, senility or organic brain syndrome • Macular degeneration, glaucoma, optic neuritis, or cataracts • An average hearing threshold sensitivity for air conduction of 40 decibels or greater	☐Y ☐N	☐Y ☐N	N/A

ENROLLMENT AND EVIDENCE OF INSURABILITY APPLICATION FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

If any of the questions below are answered "yes," please list the required health history below.

	Underwriting Questions for Life Coverage and Late Enrollment Health Coverage	EE	SP	CH
Cancer	**9.** Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any of the following? • Addison's Disease • Brucellosis • Cerebrospinal meningitis • Cystic Fibrosis • Encephalitis • Hansen's Disease • Hepatitis (Chronic B or Chronic C with liver failure or hepatoma) • 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 • Tuberculosis • Thalassemia • Tularemia • Typhoid Fever	☐Y ☐N	☐Y ☐N	☐Y ☐N
Hospital Indemnity	**10.** Is any person to be insured currently pregnant or undergoing fertility treatment by a licensed health care practitioner?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Height and Weight	**11.** Provide **Height** and **Weight** Employee (Critical Illness and Hospital Indemnity): Height:____ ft. ____ in. Weight:____ lbs. Spouse (Critical Illness): Height:____ ft. ____ in. Weight:____ lbs.			
Required Health History	**12.** Provide health history for any "Yes" answers to the Underwriting questions (except questions about AIDS or ARC). Include physician's (or other licensed health care practitioner's) name, address and telephone number: _____ _____ _____			

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers contained in this application are representations, not warranties, and are true, complete, and correctly recorded. **UNDERSTANDING**. I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the “effective date” for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no agent (producer) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION (EMPLOYEE). I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR CRITICAL ILLNESS)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, MIB, Inc. or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any minor dependent on whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

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

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Agent's (Producer's) Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Florida Agent (Producer) _____

Print Soliciting Agent (Producer) Name _____

Florida Agent License Number _____

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

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

(McCoy Federal Credit Union)
(EOI L70PA)
(2016)

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. You may request to be interviewed in connection with the report and may also receive a copy of the report upon request. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. 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.

IN/MIB-3 **(2012)**

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901. American Heritage Life or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits.

IN/MIB-3 **(2012)**

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
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