



Benefits

For State Employees

David Dearie Insurance

Hi,

Thanks! Here is the application, payroll form and brochure for the insurance you requested. Complete the application and payroll form the best you can and send it to me. I'll check it and email you when I receive it.

You can send it to me either:

By mail: David Dearie, 3001 Jodie Place, Metairie, LA 70002

By fax: 504-717-4808 (faxes come directly to my email, so it is safe)

By email: Scan and send it to dearie@cox.net

Or call me, and I will come pick it up.

Thanks again,

David Dearie

504-616-3537 cell

504-717-4808 fax

A Disability Income Insurance Policy Illustration

Issue State: **Louisiana** Type of Coverage: **Preferred**
 Agent Name: Allstate Workplace Division Elimination Period: **0 Day Accident/7 Day Sickness**
 Policy: **DI5W Disability Income (DI5WLA Rev. (9/05)) - Simplified Issue** Benefit Period: **12 Months**
 Optional Riders: **On the Job Accident Total Disability Rider (R1DI5LA)**

Maximum Monthly Benefit*	Issue Ages:	18-49	50-59	60-69
		Semi-Monthly Premium	Semi-Monthly Premium	Semi-Monthly Premium
\$5,000.00		\$110.60	\$135.10	\$209.60
\$4,900.00		\$108.43	\$132.44	\$205.45
\$4,800.00		\$106.26	\$129.78	\$201.30
\$4,700.00		\$104.09	\$127.12	\$197.15
\$4,600.00		\$101.92	\$124.46	\$193.00
\$4,500.00		\$99.75	\$121.80	\$188.85
\$4,400.00		\$97.58	\$119.14	\$184.70
\$4,300.00		\$95.41	\$116.48	\$180.55
\$4,200.00		\$93.24	\$113.82	\$176.40
\$4,100.00		\$91.07	\$111.16	\$172.25
\$4,000.00		\$88.90	\$108.50	\$168.10
\$3,900.00		\$86.73	\$105.84	\$163.95
\$3,800.00		\$84.56	\$103.18	\$159.80
\$3,700.00		\$82.39	\$100.52	\$155.65
\$3,600.00		\$80.22	\$97.86	\$151.50
\$3,500.00		\$78.05	\$95.20	\$147.35
\$3,400.00		\$75.88	\$92.54	\$143.20
\$3,300.00		\$73.71	\$89.88	\$139.05
\$3,200.00		\$71.54	\$87.22	\$134.90
\$3,100.00		\$69.37	\$84.56	\$130.75
\$3,000.00		\$67.20	\$81.90	\$126.60
\$2,900.00		\$65.03	\$79.24	\$122.45
\$2,800.00		\$62.86	\$76.58	\$118.30
\$2,700.00		\$60.69	\$73.92	\$114.15
\$2,600.00		\$58.52	\$71.26	\$110.00
\$2,500.00		\$56.35	\$68.60	\$105.85
\$2,400.00		\$54.18	\$65.94	\$101.70
\$2,300.00		\$52.01	\$63.28	\$97.55
\$2,200.00		\$49.84	\$60.62	\$93.40
\$2,100.00		\$47.67	\$57.96	\$89.25
\$2,000.00		\$45.50	\$55.30	\$85.10
\$1,900.00		\$43.33	\$52.64	\$80.95
\$1,800.00		\$41.16	\$49.98	\$76.80
\$1,700.00		\$38.99	\$47.32	\$72.65
\$1,600.00		\$36.82	\$44.66	\$68.50
\$1,500.00		\$34.65	\$42.00	\$64.35
\$1,400.00		\$32.48	\$39.34	\$60.20
\$1,300.00		\$30.31	\$36.68	\$56.05
\$1,200.00		\$28.14	\$34.02	\$51.90
\$1,100.00		\$25.97	\$31.36	\$47.75
\$1,000.00		\$23.80	\$28.70	\$43.60
\$900.00		\$21.63	\$26.04	\$39.45
\$800.00		\$19.46	\$23.38	\$35.30
\$700.00		\$17.29	\$20.72	\$31.15
\$600.00		\$15.12	\$18.06	\$27.00
\$500.00		\$12.95	\$15.40	\$22.85
\$400.00		\$10.78	\$12.74	\$18.70

These rates are for agent use only and are not to be presented to the employee without an approved case-specific marketing brochure that describes the benefits, exclusions, and limitations of this policy. Please ask your producer for details.

* The Maximum Monthly Benefit that can be applied for must be reduced by the Monthly Benefits of all other existing coverage.

David Dearie 504-616-3537 dearie@cox.net



Allstate

Workplace Division

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company, a wholly owned subsidiary of the Allstate Corporation, Home Office: Northbrook, Illinois. All products are underwritten by American Heritage Life Insurance Company, Home Office: Jacksonville, Florida. This illustration highlights some features of the policy and riders, but is not the insurance contract. Only the actual policy and certificate provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. ©2010 Allstate Insurance Company.



Account No.	Account Name	Requested Effective Date	First Deduction Date	Employee ID	Remarks
Billing Mode (choose one): <input type="checkbox"/> Monthly (12) <input type="checkbox"/> Semi-Monthly (24) <input type="checkbox"/> Bi-Weekly (26) <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Other _____					
Billing Method: <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Bank/Credit Union Draft (Authorization required - complete form ABJ062)					
AHL home office use only					Total Mode Premium

General Information

Employee/Payor Name (Last, First, M.I.)	Birth Date	Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Street Address	Phone No.		
City, State, Zip	Email Address		
Employer	Hire Date	Occupation*	

*Occupation with the employer listed in the General Information section.

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Life or Critical Illness, has the employee used tobacco in the last 12 months? **Employee** Yes No

If applying for Life or Critical Illness, has the employee's spouse used tobacco in the last 12 months? **Spouse** Yes No

Selection of Coverage

Answer yes or no and complete for each coverage selected.

GI -- Guaranteed Issue
 CGI -- Contingent Guaranteed Issue
 SI -- Simplified Issue

Accident Do you want this coverage? Yes No Section 125 **Select one:** Pre-tax Post-tax

Who do you want to cover?

Request Plan:

- Individual
- Individual + Spouse
- Individual + Child(ren)
- Family

Plan Type _____ Units _____

GI CGI SI

Monthly Earnings \$ _____

Request Riders:

Units

Request Riders:

Units

<input type="checkbox"/> APDIR		<input type="checkbox"/> AP6DF	
<input type="checkbox"/> APEXT		<input type="checkbox"/> AP6AUC	
<input type="checkbox"/> APHCR		<input type="checkbox"/> AP6ERS	
<input type="checkbox"/> BER		<input type="checkbox"/> AP6ADD	
<input type="checkbox"/> OPTR			

Mode Premium

Application for Life and Health Insurance Form

Cancer Do you want this coverage? Yes No Section 125 **Select one:** Pre-tax Post-tax

Who do you want to cover?
 Individual
 Family

Request Plan: Plan Type _____
 Choose policy options: Units _____
 Hospital _____
 Radiation/Chemotherapy _____
 Surgery Related _____
 Miscellaneous _____

Mode Premium

Request riders: Units

<input type="checkbox"/> CABR	
<input type="checkbox"/> ICR	
<input type="checkbox"/> CLR	
<input type="checkbox"/> CPR	
<input type="checkbox"/> WBR-Fixed	
<input type="checkbox"/> WBR-Variable	

Critical Illness Do you want this coverage? Yes No Section 125 **Select one:** Pre-tax Post-tax

Who do you want to cover?
 Individual
 Single Parent Family
 Family

Request Plan: Plan Type _____
 GI SI
 Basic Benefit Amount: \$ _____

Mode Premium

Request riders: Units

<input type="checkbox"/> CICR1	
<input type="checkbox"/> WBR	

Disability (DI) Do you want this coverage? Yes No Section 125 **Select one:** Pre-tax Post-tax

Request Plan: Plan Type D15W GI CGI SI

Occupation Class: Preferred Standard

Choose elimination and benefit periods:
 Elimination Period: 0 Days Accident 7 Days Sickness Benefit Period: 12 Months

Mode Premium

Provide: Monthly Earnings* \$ _____
 Monthly Benefit \$ _____
 *Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.

Request riders: Units

<input type="checkbox"/> Accidental D&D Rider	<input type="checkbox"/> Individual	<input type="checkbox"/> Family	
<input type="checkbox"/> On the Job Accident Total Disability Rider			

Hospital Indemnity (SHOP) Do you want this coverage? Yes No Section 125 **Select one:** Pre-tax Post-tax

Who do you want to cover?
 Individual
 Individual + Spouse
 Individual + Child(ren)
 Family

Request Plan: Plan Type _____ Units _____
 CGI SI

Mode Premium

Request Riders: Units **Request Riders:** Units

<input type="checkbox"/> IHR1		<input type="checkbox"/> AHNR	
<input type="checkbox"/> SAR1		<input type="checkbox"/> TR1	
<input type="checkbox"/> IPBR1		<input type="checkbox"/> ADIR1	
<input type="checkbox"/> OPBR1		<input type="checkbox"/> SDIR1	
<input type="checkbox"/> OEAR1			

Life Do you want this coverage? Yes No

Request Plan: Plan Type _____ GI CGI SI

Choose one (UL only): Death Benefit Option 1 2

Requested Face Amount \$ _____

Mode Premium

Request Riders: Units **Request Riders:** Units

<input type="checkbox"/> ADB		<input type="checkbox"/> LTC	
<input type="checkbox"/> CI		<input type="checkbox"/> PW	
<input type="checkbox"/> CTR		<input type="checkbox"/> STR/ST	
<input type="checkbox"/> TIR/LT		<input type="checkbox"/> LBR/TI	
<input type="checkbox"/> FPOR		<input type="checkbox"/> OIR	

Application for Life and Health Insurance Form

If the proposed insured is your spouse or child, provide the following information for that proposed insured.

Spouse Child

Proposed Insured Name (Last, First, M.I.)		Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Street Address		Birth Date	
City, State, Zip	Phone No.	Email Address	
Employer of Proposed Insured	Annual Salary	Occupation	

Answer if applying for spouse as proposed insured (CGI or SI Life). Is the employee's spouse 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? Yes No

Answer if applying for child as proposed insured. Is the child proposed for coverage a full-time student? Yes No

If the answer is no and the child is 19 or older, is he/she 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)? Yes No

If applying for Life coverage for a dependent child (age 19 or older) as the proposed insured, has that dependent child used tobacco in the last 12 months? Yes No

If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Provide if owner is different than the employee or the proposed insured.

Owner Name (Last, First, M.I.)		Social Security/Tax I.D. No.
Residence Street Address		Birth Date
City, State, Zip	Phone No.	Email Address

Illustration Regulation Certification for Universal Life and Term Life

The owner must select one of the following statements. Answer for proposed insured.

- I certify that I have received an illustration conforming to the coverage applied for. I will complete the applicable illustration certification form provided, if required in my state.
- I certify that I did **not** receive an illustration conforming to the coverage applied for. I understand that an illustration conforming to the coverage issued will be provided upon delivery of the policy.

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name (Last, First, M.I.)		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name (Last, First, M.I.)		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Application for Life and Health Insurance Form

Eligibility Question

Answer for the following coverages: All products

Employee Actively At Work. Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? Yes No

Underwriting Questions

If requesting Guaranteed Issue, proceed to the Replacement and Existing Insurance section. For all other enrollments, answer each question for the coverages for which you are applying. If any of the questions below are answered yes, list the required health history at the end of the section.

Answer for the following: CGI & SI Accident w/Sickness DI Rider, Cancer, SI Critical Illness, CGI & SI Disability, CGI & SI Hospital Indemnity, CGI & SI Life

1. AIDS History. In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for Acquired Immune Deficiency Syndrome (AIDS), or has any person to be insured tested positive for antigens or antibodies to an AIDS virus? **Employee** Yes No
Spouse Yes No
Child(ren) Yes No

Answer for the following: SI Life, All CGI

2. Recently Disabled/Hospitalized. In the last 6 months, has the person(s) to be insured been disabled or hospitalized for anything other than lacerations or broken bones due to an accident, or normal pregnancy? **Employee** Yes No
Spouse Yes No
Child(ren) Yes No

Answer for the following: SI Life

3. Chronic Disease History. In the last 2 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following? **Employee** Yes No
Spouse Yes No
Child(ren) Yes No

- Anemia (other than iron deficiency)
- Anxiety, depression or other mental or nervous illness (that resulted in hospitalizations, disability from work, or suicide attempts)
- Asthma (only if taking steroidal medication and/or have been hospitalized)
- Cancer, except basal cell carcinoma
- Diabetes
- Epilepsy and/or seizure disorder
- Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder
- Hemophilia
- Hepatitis
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lou Gehrig's Disease (ALS)
- Lung Disease/Disorder (other than asthma)
- Lupus
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation
- Transplant of any organ
- Counseling for, or excessive use of, alcohol or any type of drugs

Answer for the following: SI Accident w/Sickness DI Rider, Cancer w/Intensive Care, SI Critical Illness, SI Disability, SI Hospital Indemnity, SI Life

4. Blood Pressure History. In the last year, has the person(s) to be insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once that was confirmed by a member of the medical profession? **Employee** Yes No
Spouse Yes No
Child(ren) Yes No

Answer for the following: SI Life

5. Driving History. In the last 3 years, has the person(s) to be insured had his/her driver's license suspended or revoked due to driving violations, been convicted of reckless driving or driving under the influence, been involved in 3 or more motor vehicle accidents, or received 3 or more moving violations? If yes, provide details including license number and state of issue. **Employee** Yes No
Spouse Yes No
Child(ren) Yes No

Application for Life and Health Insurance Form**Answer for the following:** Cancer, SI Critical Illness Cancer Option, SI Hospital Indemnity**6a. Cancer Diagnosis/Treatment History.** Has a member of the medical profession ever diagnosed or treated the person(s) to be insured for any type of cancer (except basal cell carcinoma)?**Employee** Yes No**Spouse** Yes No**Child(ren)** Yes No**6b. Cancer Leukemia/Lymphoma.** If the answer to the Cancer Diagnosis/Treatment History question is yes, has a member of the medical profession diagnosed or treated that person(s) for Leukemia, Hodgkin's Disease, Lymphoma, or cancer with any lymph node involvement or metastasis?**Employee** Yes No**Spouse** Yes No**Child(ren)** Yes No**6c. Cancer Other.** If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a member of the medical profession diagnosed or treated that person(s) for any other type of cancer (other than those listed in the Cancer Leukemia/Lymphoma question and/or basal cell carcinoma)?**Employee** Yes No**Spouse** Yes No**Child(ren)** Yes No**Answer for the following:** SI Accident w/Sickness DI Rider, SI Critical Illness, SI Disability**7. Major Medical Condition History.** In the last 2 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?**Employee** Yes No**Spouse** Yes No**Child(ren)** Yes No

- Cancer (except basal cell carcinoma)
- Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)
- Chronic Fatigue Syndrome
- Counseling for alcohol or drug abuse
- Diabetes
- Emphysema
- Fibromyalgia
- Heart Disease/Disorder
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lung Disease/Disorder
- Lupus
- Optic Neuritis
- Pancreas Disease
- Parkinson's Disease
- Paralysis
- Rheumatoid Arthritis
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation

Answer for the following: SI Accident w/Sickness DI Rider, SI Disability**8. Back/Asthma History.** In the last 2 years, has the person(s) to be insured had any disease of, been impaired by, or received treatment from a member of the medical profession for, the following (other than minor illness)? If yes, complete exclusion endorsement if applying for sickness disability rider.**Employee** Yes No

- Any disorder of the back or neck
- Asthma

Answer for the following: Cancer w/Intensive Care, SI Hospital Indemnity**9. Heart/Stroke History.** In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?**Employee** Yes No**Spouse** Yes No**Child(ren)** Yes No

- Any artery disease
- Any abnormality of the heart
- Heart attack
- Heart condition
- Heart trouble
- Stroke or transient ischemic attack (TIA)

Answer for the following: SI Accident w/Sickness Disability Rider, SI Critical Illness, SI Disability, SI Hospital Indemnity, SI Life**10. Advised Medical Procedure History.** In the last 5 years, has a member of the medical profession advised or recommended that the person(s) to be insured have any medical or surgical procedures (including organ transplant), which have not yet been performed?**Employee** Yes No**Spouse** Yes No**Child(ren)** Yes No**Provide height and weight.****11. Employee for the following:** SI Life, SI Accident w/Sickness Disability Rider, SI Critical Illness, SI Disability, SI Hospital Indemnity**Height:** _____ ft. _____ in **Weight:** _____ lbs.**Spouse for the following:** SI Life (when proposed insured)**Height:** _____ ft. _____ in **Weight:** _____ lbs.**Child for the following:** SI Life (when proposed insured)**Height:** _____ ft. _____ in **Weight:** _____ lbs.

Application for Life and Health Insurance Form

Answer for the following: SI Critical Illness (over \$50,000), SI Life (over \$150,000)

12. Physician Information. Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured. The required health history section may be used if additional space is needed.

Answer for the following: All products

13. Required Health History. Provide health history for any yes answers to the underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number:

Replacement and Existing Insurance

Replacement (Answer for proposed insured for all products). Will the insurance being applied for replace or change any existing life or health coverage that you currently have? If yes, indicate product being replaced or changed and complete replacement form provided if required by your state. Yes No

Existing Insurance (Answer for all insureds for all products). Is there any other insurance you didn't list that exists (or that you have applied for on another application with AHL or another company) for the person(s) to be insured? This would be insurance that corresponds to the coverage for which you are applying. If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. Yes No

REPRESENTATION. I have read or had read to me this completed form and understand that any misstatement or misrepresentation in this form may result in loss of coverage. I represent that statements and answers given on this form are true, complete, and correctly recorded. **UNDERSTANDING.** I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the "effective date" for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, AHL will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. **I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such form may be declined on the basis of such proof. PREMIUM DEDUCTION AUTHORIZATION (EMPLOYEE).** I AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND 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 for whom insurance is requested. This authorization is valid for 24 months from the date signed or until I have cancelled the policy or I am no longer covered under the policy. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

Hospital Indemnity: I ACKNOWLEDGE THAT THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN ADDITIONAL PAYMENT WITH MY TAXES.

Application for Life and Health Insurance Form

I hereby attest that I am purchasing this policy as a supplement or in addition to other major medical health insurance coverage, also know as "minimum essential coverage."

FRAUD NOTICE: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature (If employee is not the owner, owner must sign) _____ City/State _____ Date Signed _____

Proposed Insured Signature _____ City/State _____ Date Signed _____

Owner Signature (If not employee) _____ City/State _____ Date Signed _____

Soliciting producer must complete and sign

Replacement -- All Products. To your knowledge, is change or replacement involved? Yes No

Existing Insurance -- All Products. To your knowledge, does any person to be insured have existing coverage in force? Yes No

Life Illustration -- Select one of the following statements.

I certify that an illustration conforming to the coverage applied for was provided. I will complete the applicable illustration certification form provided, if required.

I certify that **no** illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the policy.

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.

Soliciting Producer Signature _____

Soliciting Producer Name Printed _____

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer			Soliciting Producer		

American Heritage Life Insurance Company

State of Louisiana Employee Payroll Deduction Authorization										
Employee Name				Soc. Sec. No.		Employee No. (for agency use)				
Agency No.			Department/Agency/Section Name							
I hereby authorize my employer to deduct a total of \$ _____, monthly rate, from my salary until further notice and remit same to American Heritage Life . A TOTAL Semi-Monthly Deduction in the amount of \$ _____ represents one half of the total monthly premium required for the coverage(s) detailed below. The Office of State Uniform Payroll and the employing agency are <u>not</u> representatives or agents of the employee or the vendor. It is the responsibility of the <u>employee</u> to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the <u>employee and the vendor</u> to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to both the vendor and his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the ISIS HR payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction are the employee's responsibility to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the <u>employee and</u> the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.										
DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS										
PRODUCT NAME	PLAN PART			125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.		
	CD	YES	NO							
Cancer	25		N	Y	\$	NA	\$			
Cancer	25	P		Y	\$	PA		\$		
SUBTOTALS					Non-Part. - Part.		\$	\$		
Accident	27		N	N	\$	NN	\$			
Disability Income	22		N	N	\$	NP	\$			
Universal Life	32		N	N	\$	NS	\$			
					Total Mo. Prem. \$					
PP Begin Date					Total Semi-Mo. Ineligible		\$			
					Total Semi-Mo. Non-Part.		\$			
Date Authorized							Total Semi-Mo. Part.		\$	
By: _____								TOTAL SEMI-MONTHLY		\$
Employee Signature										
(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)										
Presentation and deduction authorization processed by:										
_____				AHL Representative			Phone		Date	

Address										