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

American Heritage Life Insurance Company

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 Semi-Monthly Premium	50-59 Semi-Monthly Premium	60-69 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

ver 12.23.2009

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

Allstate. BENEFITS

Application for Life and Health Insurance Form

Account No.	Account Name	Requested Effective Date	First Deduction Date	Employee ID	*Remarks*

Billing Mode *(choose one)*: ☐ Monthly (12) ☐ Semi-Monthly (24) ☐ Bi-Weekly (26) ☐ Weekly (52) ☐ Other _____

Billing Method: ☐ Payroll Deduction ☐ 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.	☐ Male ☐ 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?

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

Mode Premium

Request Plan:

Plan Type _____ Units _____

☐ GI ☐ CGI ☐ SI

Monthly Earnings $ _____

Request Riders:	Units	Request Riders:	Units
☐ APDIR		☐ AP6DF	
☐ APEXT		☐ AP6AUC	
☐ APHCR		☐ AP6ERS	
☐ BER		☐ AP6ADD	
☐ OPTR			

Employee Name _____ Account No. _____

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

Mode Premium

Request Plan: Plan Type _____

Choose policy options: Units
- Hospital _____
- Radiation/Chemotherapy _____
- Surgery Related _____
- Miscellaneous _____

Request riders: Units

☐ CABR	
☐ ICR	
☐ CLR	
☐ CPR	
☐ WBR-Fixed	
☐ 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

Mode Premium

Request Plan: Plan Type _____

☐ GI ☐ SI

Basic Benefit Amount: $ _____

Request riders: Units

☐ CICR1	
☐ WBR	

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

Request Plan: Plan Type 715W ☐ 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

☐ Accidental D&D Rider	☐ Individual	☐ Family	
☐ 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

Mode Premium

Request Plan:

Plan Type _____ Units _____

☐ CGI ☐ SI

Request Riders:	Units	Request Riders:	Units
☐ IHR1		☐ AHNR	
☐ SAR1		☐ TR1	
☐ IPBR1		☐ ADIR1	
☐ OPBR1		☐ SDIR1	
☐ 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
☐ ADB		☐ LTC	
☐ CI		☐ PW	
☐ CTR		☐ STR/ST	
☐ TIR/LT		☐ LBR/TI	
☐ FPOR		☐ OIR	

Employee Name _____ Account No. _____

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.	☐ Male ☐ 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.	

Employee Name _____ Account 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

Employee Name _____ Account 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?

- 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

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

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.

- Any disorder of the back or neck
- Asthma

Employee	☐ Yes	☐ No

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?

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

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

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.

Employee Name _____ Account No. _____

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.

Employee Name _____ Account No. _____

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		

SED-4 (R 01/10)

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 **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the **employee and the vendor** 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 employee **and** 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 CD	YES	NO	125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
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: _____ Employee Signature	**TOTAL SEMI-MONTHLY**		$

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by:

_____ AHL Representative _____ Phone _____ Date

_____ Address