Allstate FINANCIAL

Workplace Division

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

GROUP VOLUNTARY CANCER/SPECIFIED DISEASE ENROLLMENT FORM

PLAN TYPE (one box must be selected): Type 1. ☐ Type 2. ☐ Type 3. ☐

EMPLOYEE'S NAME Last First M.I.	SEX ☐ Male ☐ Female	BIRTHDATE Month/Day/Year	SOCIAL SECURITY NUMBER	
EMPLOYEE'S ADDRESS Street City State Zip	EMPLOYER		DATE HIRED Month/Day/Year	COVERAGE TYPE: ☐ Individual ☐ Family

FAMILY COVERAGE (if applicable) List all your eligible dependents below:

Name	Social Security Number	Sex	Date of Birth	Relationship

	Unit(s)	Total Mode Premium	Premium/Billing Mode	
Hospital Benefits				
Radiation/Chemotherapy Benefits		$	Monthly	☐
Surgery/Related Benefits			Semi-Monthly	☐
Miscellaneous Benefits			Bi-Weekly	☐
Initial Diagnosis Option ☐			Weekly	☐
Intensive Care Option ☐			Other	☐
Cancer Screening Option ☐				

Group Case Situs State	Group Case Name	Group Case Number
Section 125 Yes ☐ No ☐	Date of First Deduction	Requested Effective Date

Agent Name	Agent Number	Percentage Credit
		%
		%
		%
		%

Home Office Use

I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested above. This signature also verifies the accuracy of the information on this enrollment 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 _____ Date Signed _____