KLEIN ISD
FUTURE READY

Keeping You Connected

Memorandum

Effective September 1, 2016, KISD will no longer be offering the Allstate Group Cancer plan and will instead offer a more comprehensive Voya Critical Illness insurance. The critical illness policy pays a lump sum of either $10,000 or $20,000 upon the diagnosis of a covered illness. Although it will include coverage for a cancer diagnosis, it is possible that the benefit received under the new critical illness plan would be less than the amount that would be payable under the current cancer plan. If you are receiving this notice it is because our records indicate that you are currently enrolled in the existing plan and we'd like to make you aware of all your options.

In an effort to avoid anyone inadvertently losing coverage all current policy holders will automatically be enrolled in the new critical illness plan. Please note that although you will be transferred to the corresponding plan tier (i.e. Allstate High Plan w/ Family will change to Voya High Plan w/ Family, etc.), the critical illness premiums are based on your age and will differ from what you are currently paying.

1. **You can keep your current policy through Allstate.** In order to set this up, you must complete a short portability form, beginning 9/1/16 premium payments will be made directly to Allstate instead of payroll deduction. ***If you are currently undergoing cancer treatment or have had any treatments in the past 12 months, we would highly recommend keeping your current coverage***. Although the new critical illness plan is guaranteed issue, meaning you won't be denied coverage regardless of your medical history, there may be limitations on the benefits it will pay. If you have any questions or concerns about whether or not to keep your coverage, please call us at 281-681-9595 and we would be happy to discuss your options in further detail. If you do not want the new Critical Illness plan you must go through online enrollment and deselect/waive the Critical Illness plan that rolled over.
2. **You may keep your current Cancer coverage, and enroll in the more comprehensive critical illness policy.** The plans are independent of one another and therefore you can receive benefits from both policies for the same diagnosis. Since the Critical Illness plan will roll over, you should go through online annual enrollment and be sure the correct plan and dependents are covered. The new rates can be found in the attached information as well as on the KISD Benefits Website (**www.mybenefitshub.com/kleinisd**).
3. **You can choose to drop your current coverage and enroll in the new critical illness plan.** To drop the current Allstate Group Cancer coverage, no action is necessary. Since the Critical Illness plan will roll over, you should go through online annual enrollment and be sure the correct plan and dependents are covered.

Carefully review the benefits of each plan because if you let your current coverage lapse you will NOT be able to re-enroll in the Allstate Group Cancer plan in the future.

A plan description, including rates, regarding this coverage will be in the annual enrollment information and can also be found on the KISD Benefits Website (**www.mybenefitshub.com/kleinisd**). After reviewing these documents if you continue to have any questions or need assistance completing the included portability forms, please call Highlander Financial at **281-681-9595**.

Allstate
Workplace Division

Policyholder's Change and Service Request

For American Heritage Life Insurance Company (Home Office: Jacksonville, FL)

Policy Number (use separate form per policy)	Name of Insured (Last, First, Middle)	Agent Name and Number (Please Print) HIGHLANDER FINANCIAL SRVS INC 4YTR0

Take the following action(s) regarding this policy subject to AHL's current rules.

1. ☐ Policy Changes, Reductions or Removals

☐ Change from *Family* to *Individual* coverage on health policy due to _____.
If due to death of Insured, Name of New Insured _____,
SS#, _____ Date of Birth _____.

☐ Add Newborn child (if no underwriting required)
Name of Newborn _____.
Date of Birth of Newborn _____.

☐ Reduce the amount of insurance From To
Basic Policy _____ _____
_____ _____ _____

☐ Remove the following Benefit Rider _____

☐ Change Death Benefit Option from 2 to 1 (if changing from 1 to 2, application must be submitted for underwriting purposes)

☐ Cancel Life policy when replacement policy is issued (for life policies with no fund value)

2. ☐ Annuity or UL Partial Surrender (Withdrawal)

$_____ or the maximum allowed by policy, if less.
*Under UL Policy, the death and fund value will be reduced by the amount of partial surrender.
*Service Fees or surrender charges will be deducted from fund value.
Note: Form C-123 also required with this request.

3. ☐ Policy Loan

☐ $_____ in cash.
☐ For maximum amount available.
☐ To pay current premium due on policy number(s) _____
☐ Other _____
☐ **Automatic Premium Loan. Make the Automatic Premium Loan Provision:**
☐ Operative ☐ Inoperative
This loan plus any other debt owed AHL is a first lien against the policy values.
There are no proceedings in bankruptcy pending against any owner signing this form.

4. ☐ Dividend Withdrawal

☐ $_____ in cash.
☐ For maximum amount available.
☐ To pay current premium due on policy number(s) _____
☐ To apply to loan on policy number _____
☐ Other _____

5. ☐ Maturity Request

☐ I elect option number _____ as stated in my contract.
Payments to be made ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
If applicable, payments to be made for a period of _____ Years.
☐ Change Maturity Date to _____.
☐ Change Maturity Age to _____.
Note: If requesting a maturity option, for C-123 also required.

6. ☐ Flexible Premium Payment Changes (FPA or UL only)

☐ Place policy in non-billing status
☐ Place policy back into a premium paying status.
☐ Change premium to $_____.
(Per ☐ Week ☐ Month ☐ Semi-Annual ☐ Annual)
☐ Make change effective _____.

7. ☐ Change Name of

☐ Insured ☐ Owner ☐ Payor
From _____ To _____
Reason for change _____ (Complete change of Address Form if needed.)
Note: If the reason for the change of name is other than marriage, a certified copy of the court order is required.

8. ☐ Address Change

Name (Last, First, Middle)
Street
City State Zip

Other Policy Numbers to be changed

(Signatures on Next Page)

Policy Number (use separate form per policy)	Name of Insured (Last, First, Middle)	Agent Name and Number (Please Print) HIGHLANDER FINANCIAL SRVS INC 4YTR0

Take the following action(s) regarding this policy subject to AHL's current rules.

9. ☐ **Guaranteed Option Requests**	☐ Change Automatic Option to (if applicable): ☐ Reduced Paid-Up ☐ Extended Term ☐ Stop Premium and Adjust Coverage to (if applicable): ☐ Reduced Paid-Up ☐ Extended Term *supplemental benefits cancel when premiums stop
10. ☐ **Transfer of ownership to** (Do not use for collateral assignment)	All policy ownership rights will vest in the new owner shown below. New Owner (Last, First, Middle) | Soc. Sec. # / F.E.I.N # Address (Street, City, State, Zip) At the death of the new owner, the successor owner is: ☐ Insured, or ☐ _____ *If a change of beneficiary is desired, it must be requested on form B-040, by the new owner. *This transfer is subject to the term of any irrevocable beneficiary designation in effect or any other ownership restrictions.
11. ☐ **Premium Mode Change to** (Direct Bill only)	☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Pre-authorized Check Plan (PAC) *PAC authorization and voided check required. Date of first deduction: _____
12. ☐ **Payroll Allotment Billing Changes**	☐ Case No. _____ ☐ Control No. _____ ☐ Payor Name _____ ☐ Place policy on Direct Bill ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Pre-authorized Check Plan (PAC) *PAC authorization and voided check required. *At least one month's premium required. Check for $_____ attached.
13. ☐ **Application for Duplicate Policy or Certificate**	I certify that the above policy has been lost or destroyed and that said policy is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request the issuance of a duplicate of said policy and agree that should the original policy be found or in any way come into my possession, I will return or cause the same to be returned to American Heritage Life Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original policy shall become null and void immediately upon issuance of the duplicate policy herein requested. I also agree that if duplicate forms of the lost policy are not available, I will accept a Certificate for Lost Policy.
14. ☐ **Other Instructions** (Be specific)	
15. ☐ **Request for Conversion to Individual Policy from Group Coverage** (Be Specific)	☐ Cancer ☐ Other Current Billing Address: _____ Employer: _____ Group Policy Number: _____ Certificate Number: _____ What policy do you want to convert to: _____ Application for the converted policy must be made to us within 31 days (within 60 days of final divorce decree in case of divorce) after the coverage terminates. The effective date of the converted policy will be the date on which this coverage terminated.
Note: For corporate owner, provide corporation's name, two officer's signatures and their titles	Owner _____ Date _____ Owner _____ Date _____ Assignee (if applicable) _____ Date _____

Agent Use Only – Subject to AHL rules, send all items to be returned to: ☐ **Agent** ☐ **Owner**	**Home Office Use Only – Date Recorded** _____ **By** _____ **To Be Effective On** _____

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224
1-800-521-3535

Payment Authorization

Use this form to authorize us to electronically deduct money from your checking or savings account to pay for American Heritage Life Insurance Company coverages.

1. Account Holder/Policy Owner Information

Account Holder/Policy Owner Name:_____ Phone:_____

Address:_____ State:_____ ZIP:_____

2. Account Information

Name of Financial Institution:_____

City: _____ State:_____ ZIP:_____

ACH/Routing Number_____ Account Number_____ ☐ Checking ☐ Savings

3. New Account Deduction Information

Please choose the day of the month for the deductions:_____ (Choose any day 1–28.)

4. Existing Account Deduction Information

If you are currently on payroll deduction and want to move to direct billing, please complete this section.

Deductions will be made monthly for the following policies:

Policy Number	Policyholder Name	Monthly Premium

Total Monthly Deduction: _____

5. Authorization

I authorize American Heritage Life Insurance Company ("AHL") to initiate debit entries electronically to my account monthly in the amount indicated above and I authorize the financial institution named above to debit same to such account. This authorization remains effective and in full force until AHL and the financial institution have received written notification from me of its termination in such time and in such manner to afford AHL and the financial institution a reasonable opportunity to act on it.

Account Holder/Policy Owner Signature:_____ Date:_____

6. Deliver this authorization to:

Fax to: 1-866-428-2516
Attn: Premium Administration Team 2

Mail to: Allstate Benefits
Attn: Premium Administration Team 2
1776 American Heritage Life Drive
Jacksonville, FL 32224