AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

☐ New Certificate
☐ Change/Increase Certificate # _____

ENROLLMENT FORM

Remarks

GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc.)	First	M.I.	SEX	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
RESIDENT ADDRESS (Street or P.O. Box)			CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER		EMPLOYER		DATE HIRED (MM/DD/YEAR)
JOB TITLE			PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)
EMPLOYEE'S EMAIL	BENEFICIARY'S NAME (Last, First, M.I.)				RELATIONSHIP

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?

Short-Term Disability	☐ Yes ☐ No	**Hospital Indemnity**	☐ Yes ☐ No
Cancer/Specified Disease	☐ Yes ☐ No	**Heritage Choice Dental**	☐ Yes ☐ No
Accident	☐ Yes ☐ No	**Critical Illness**	☐ Yes ☐ No

If "yes", indicate type of change: _____

Date of change _____ Current Certificate Number _____

Do you currently have any of the following individual products with AHL?

Cancer ☐ Yes ☐ No Accident ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

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

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

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Abbreviations: DIR-Riders available with STD Can-Cancer Acc-Accident Hosp-Hospital Den-Dental CI-Critical Illness

Choose Plan(s): DIR	Can	Acc	Hosp	Den	CI	**Dependent's Name** (Last, First, M.I.)	**Relationship**	**Sex**	**Date of Birth** (MM/DD/YEAR)	**Social Security Number**

Premium/Billing Mode	Case Number	Agent Number	Percentage Credit
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other _____	Employee ID		
Date of Issue _____	Situs State		

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Short-Term Disability ☐ Yes ☐ No	Monthly Salary $_____ / Monthly Benefit $_____	Elimination Period _____ Days Acc. _____ Days Sick. / Benefit Period _____ Months	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only** SET ID/PLAN ID **ACTIV/STD** _____ and/or **EMPLR/STD** _____ and/or (other) _____

Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Rider Units							

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No

If yes, provide the Company Name: _____

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, complete the following:

Company Name: _____ Year Issued: _____

Monthly Benefit: _____ Elimination Period: _____ Benefit Period: _____

Cancer/Specified Disease ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option ☐	Intensive Care Option ☐	Wellness Option ☐
Units				1			

Strike/Layoff Riders: (Only one Rider may be selected.)

☐ Continuation During Strike or Layoff Rider ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Accident ☐ Yes ☐ No	Base Units _____	Benefit Enhancement Rider ☐ Units: _____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Optional Disability Riders for Employee ☐ Off the Job Accident ☐ Off the Job Accident and Sickness ☐ On and Off the Job Accident ☐ On and Off the Job Accident and Sickness	Employee Monthly Salary $_____	Rider Units _____
Optional Disability Riders for Spouse ☐ On and Off the Job Accident for Insured Spouse* ☐ On and Off the Job Accident and Sickness for Insured Spouse* ***Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.**	Spouse Monthly Salary $_____	Rider Units _____

Strike/Layoff Riders: (Only one Rider may be selected.)

☐ Continuation During Strike or Layoff Rider ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Hospital Indemnity ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option ☐	Prescription Drug Option ☐	Disability Rider ☐	Life Rider ☐
Units							

Strike/Layoff Riders: (Only one Rider may be selected.)

☐ Continuation During Strike or Layoff Rider ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee + One ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes", please enter the date coverage effective _____	**Home Office Use Only** SET ID **ACTIV** or **EMPLR** or _____ PLAN ID **P1NG1 P1NG2 P1NG3**

Must Complete This Section If Enrolling In Any Critical Illness Product	Has any person to be insured (employee or spouse) used tobacco in any form in the last 12 months? ☐ Yes ☐ No Do you currently have any Critical Illness products with AHL? ☐ Yes ☐ No If "Yes", please enter the Policy Number _____ Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination _____

Employee Paid Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	**Basic Benefit Amount $**_____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.	Total Mode Premium $ _____

Cancer CI Option ☐	2nd Event Cancer CI Option ☐	2nd Event CI Option ☐	Supp. CI Option I (HIV) ☐	Supp. CI Option II ☐	Inc. CI Benefit ☐ Units:_____	Wellness Option ☐ Units: _____

Strike/Layoff Riders: (Only one Rider may be selected.)
☐ Continuation During Strike or Layoff Rider ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Critical Illness (GVCIP1) (My Lifeline) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____	**Home Office Use Only** SET ID _____

Basic Benefit Amount $ _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.	Critical Illness Cancer Option ☐	Recurrence Option ☐	Wellness Option ☐ Units _____

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: www.allstateatwork.com/mybenefits.

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my Certificate, free of charge, by calling, toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

☐ YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.
☐ NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.

ACCEPTANCE: I hereby request all coverage checked "yes" above for which I am or may become eligible under the group coverages issued by AHL. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed. · **WAIVER/DECLINATION**: I understand that if I refuse any coverage for which I am eligible (by checking "no" above), 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.
FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Date Signed _____ Employee's Signature _____

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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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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