AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate Benefits

☐ 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.?

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?

Accident ☐ Yes ☐ No Critical Illness ☐ 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: Acc-Accident CI-Critical Illness

Choose Plan(s): Acc	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)

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

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: _____

Has any person to be insured (employee or spouse) used tobacco in any form in the last 12 months? ☐ Yes ☐ No

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.

Date Signed _____ Employee's Signature _____

Allstate
Workplace Division

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).