



Allstate

Benefits

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks: This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

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

PERSONS TO BE COVERED SECTION

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

Name (Last, First, M.I.) Relationship Sex Date of Birth (MM/DD/YEAR) Social Security Number Used tobacco in any form in the last 12 months? Employee Spouse * If applying for Life or Critical Illness

Do you currently have any of the following individual products with American Heritage Life Insurance Company (AHL)?

Accident ☐ Yes ☐ No Cancer ☐ 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 _____

Premium/Billing Mode ☒ Semi-Monthly Case Number 13536 Producer/ Agent Number T0252 Percentage Credit Employee ID Date of First Deduction Requested Issue Date Situs State WI T057W

ENROLLMENT FORM SELECTION OF COVERAGE SECTION

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

Accident (GVAP2) (Off the Job Accident) <input type="checkbox"/> Yes <input type="checkbox"/> No	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Semi-Monthly Premium: <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Low</td> <td style="text-align: center;">High</td> </tr> <tr> <td>Employee Only</td> <td style="text-align: center;"><input type="checkbox"/> \$6.13</td> <td style="text-align: center;"><input type="checkbox"/> \$9.26</td> </tr> <tr> <td>Employee + Spouse</td> <td style="text-align: center;"><input type="checkbox"/> \$8.88</td> <td style="text-align: center;"><input type="checkbox"/> \$13.47</td> </tr> <tr> <td>Employee + Child(ren)</td> <td style="text-align: center;"><input type="checkbox"/> \$12.43</td> <td style="text-align: center;"><input type="checkbox"/> \$18.74</td> </tr> <tr> <td>Family</td> <td style="text-align: center;"><input type="checkbox"/> \$15.54</td> <td style="text-align: center;"><input type="checkbox"/> \$23.43</td> </tr> </table>		Low	High	Employee Only	<input type="checkbox"/> \$6.13	<input type="checkbox"/> \$9.26	Employee + Spouse	<input type="checkbox"/> \$8.88	<input type="checkbox"/> \$13.47	Employee + Child(ren)	<input type="checkbox"/> \$12.43	<input type="checkbox"/> \$18.74	Family	<input type="checkbox"/> \$15.54	<input type="checkbox"/> \$23.43
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Family	<input type="checkbox"/> \$15.54	<input type="checkbox"/> \$23.43															
Low Plan - 2 units Accident, 1 unit Benefit Enhancement Rider & 3 units Outpatient Physician's Rider High Plan - 3 units Accident, 2 units Benefit Enhancement Rider & 4 units Outpatient Physician's Rider																	

Cancer/Specified Disease (GVCP3) <input type="checkbox"/> Yes <input type="checkbox"/> No	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Semi-Monthly Premium: <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Low</td> <td style="text-align: center;">Medium</td> <td style="text-align: center;">High</td> </tr> <tr> <td>Employee Only</td> <td style="text-align: center;"><input type="checkbox"/> \$8.47</td> <td style="text-align: center;"><input type="checkbox"/> \$12.18</td> <td style="text-align: center;"><input type="checkbox"/> \$18.07</td> </tr> <tr> <td>Employee + Spouse</td> <td style="text-align: center;"><input type="checkbox"/> \$13.44</td> <td style="text-align: center;"><input type="checkbox"/> \$19.03</td> <td style="text-align: center;"><input type="checkbox"/> \$28.48</td> </tr> <tr> <td>Employee + Child(ren)</td> <td style="text-align: center;"><input type="checkbox"/> \$11.69</td> <td style="text-align: center;"><input type="checkbox"/> \$17.05</td> <td style="text-align: center;"><input type="checkbox"/> \$25.74</td> </tr> <tr> <td>Family</td> <td style="text-align: center;"><input type="checkbox"/> \$16.65</td> <td style="text-align: center;"><input type="checkbox"/> \$23.89</td> <td style="text-align: center;"><input type="checkbox"/> \$36.14</td> </tr> </table>		Low	Medium	High	Employee Only	<input type="checkbox"/> \$8.47	<input type="checkbox"/> \$12.18	<input type="checkbox"/> \$18.07	Employee + Spouse	<input type="checkbox"/> \$13.44	<input type="checkbox"/> \$19.03	<input type="checkbox"/> \$28.48	Employee + Child(ren)	<input type="checkbox"/> \$11.69	<input type="checkbox"/> \$17.05	<input type="checkbox"/> \$25.74	Family	<input type="checkbox"/> \$16.65	<input type="checkbox"/> \$23.89	<input type="checkbox"/> \$36.14
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Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	<input checked="" type="checkbox"/> Cancer Initial Diagnosis Option	<input checked="" type="checkbox"/> Intensive Care Option	<input checked="" type="checkbox"/> Wellness Option															
Units																						
Low Plan	2	2	1	1	2	2	4															
Medium Plan	2	4	2	1	2	2	4															
High Plan	3	6	2	1	5	6	4															

 Critical Illness (GVCIP2) <input type="checkbox"/> Yes <input type="checkbox"/> No 	 <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family 	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Semi-Monthly Premium \$ _____
Basic Benefit Amount \$ <input type="checkbox"/> \$10,000 -or- <input type="checkbox"/> \$20,000 If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.	<input checked="" type="checkbox"/> 2 nd Event Cancer Critical Illness Option	<input checked="" type="checkbox"/> 2 nd Event Critical Illness Option	

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 remain covered. 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 _____



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>
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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

<p>Before You Buy This Insurance</p>

- ✓ 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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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

<p>Before You Buy This Insurance</p>

- ✓ 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 (SHIP).

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