AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate Benefits

ENROLLMENT FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only

GENERAL INFORMATION

Employee's/Payor's/Owner's (Certificateholder) Name (Last, First, M.I.)		☐ M ☐ F	Social Security Number	
Residence Address		City	State	Zip
Date of Birth	Phone Number	Email		
Employer/Association/Union	Date Hired	Occupation	Plant Or Division	
Primary Beneficiary's Full Name and Address Addendum 1	City State Zip		Relationship	
Phone Number	Date of Birth	Social Security Number		
Contingent Beneficiary's Full Name and Address	City State Zip		Relationship	
Phone Number	Date of Birth	Social Security Number		

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use* (Critical Illness)
		Employee				☐ Yes ☐ No
						☐ Yes ☐ No

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months?**

Are you applying for coverage or changing existing coverage due to a qualifying event?

Accident ☐ Yes ☐ No

Critical Illness ☐ Yes ☐ No

If "Yes", check the qualifying event:

☐ Marriage ☐ Spouse/Dependent Child Death ☐ Newly Eligible
☐ Divorce ☐ Eligible/Ineligible Child ☐ Termination
☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Employee Death

Date of Qualifying Event _____ Current Certificate Number(s) _____

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

Accident ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No Addendum 1

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

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination Addendum 1

Do you currently have comprehensive health benefits from either an insurance policy or an HMO? ☐ Yes ☐ No
If you have answered "No," you may not apply for Critical Illness coverage.

Premium/Billing Mode	Account Number	Employee ID	Situs State
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other			
Date of First Deduction _____ Coverage Effective Date _____			

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Accident (GVAP6) ☐ Yes ☐ No	Base Units ☐ **Low Plan** ____ ☐ **High Plan** ____	☐ Employee Only ☐ Employee+Child(ren) ☐ Employee+Spouse ☐ Family	**Home Office Use Only**

☐ Accident Treatment & Urgent Care Rider	**Units** ____	☐ Dislocation/Fracture Rider	**Units** ____
☐ Emergency Room Services Rider	**Units** ____	☐ Benefit Enhancement Rider	**Units** ____
☐ Outpatient Physician's Rider	**Units** ____		

Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Child(ren) ☐ Employee+Spouse ☐ Family	**Home Office Use Only**

Basic Benefit Amount $ _____	☐ Wellness Option Units ____	☐ Cancer Critical Illness Option

Eligibility Question		**EMPLOYEE**
Accident & Critical Illness	Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **UNDERSTANDING**. I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the "effective date" for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. 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. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Signature of Owner, if other than Insured _____

Signature of Employee/Payor, if not Insured or Owner _____

To be completed by home office or producer, prior to issue:

Producer Name	**Producer Number**	**National Producer Number (NPN)**	**Percentage Credit**
Servicing Producer:			%
			%
			%
			%
			%