AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate Benefits

☐ New Certificate
☐ Change/Increase Certificate # _____

ENROLLMENT FORM
GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

SUBSCRIBER'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
BIRTH DATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER	DATE HIRED (MM/DD/YEAR)
JOB TITLE	REHIRE DATE (MM/DD/YEAR)		
SUBSCRIBER'S EMAIL	BENEFICIARY'S NAME (Last, First, M.I.)	RELATIONSHIP	

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

SELECTION OF COVERAGE SECTION

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

Accident		Base Units:	Benefit Enhancement Rider	Total Monthly Premium:
☐ Yes ☐ No	☐ Member Only ☐ Member+Spouse ☐ Member+Child(ren) ☐ Family	☐ Low Plan: **1 Unit** or ☐ High Plan: **2 Units**	Units: **1**	$ _____ *refer to rates

Critical Illness (GVCIP2)		Basic Benefit Amount:	Total Monthly Premium
☐ Yes ☐ No	☐ Member Only ☐ Member+Spouse ☐ Member+Child(ren) ☐ Family	☐ Low Plan **$10,000** or ☐ High Plan **$20,000** If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the member.	$ _____ *refer to rates

Cancer CI Option	2nd Event Cancer CI Option **N/A**	2nd Event CI Option **N/A**	Supp. CI Option I (HIV)	Supp. CI Option II **N/A**	Inc. CI Benefit Units: **N/A**	Wellness Option Units: **2**

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

Premium Mode	Situs State	Case Number	Agent Number	Percentage Credit
Monthly Date of Issue _____	**MI**		**8LTT0**	**100%**

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 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 _____ Member's Signature _____

ACTION REQUIRED: Please complete and sign this application.

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).