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
Employee is Actively at Work	

GENERAL INFORMATION

Employee's Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union: Hillsborough County Clerk of Circuit Court / Date Hired	Occupation	Plant Or Division: Clerk of Circut Court	
Primary Beneficiary's Full Name and Address / 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
		Spouse				** ☐ Yes ☐ No

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Critical Illness.)**

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

Accident ☐ Yes ☐ No **Critical Illness** ☐ Yes ☐ No
Cancer/Specified Disease ☐ Yes ☐ No **Hospital Indemnity** ☐ 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 Cancer ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

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 _____

Premium/Billing Mode ☒ Bi-Weekly	Account Number	Employee ID	Situs State
Date of First Deduction 01-01-2020 Coverage Effective Date 01/01/2021			FL

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Accident (GVAP1) (On and Off the Job Accident) ☐ Yes ☐ No	Base Units 2	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Premium $_____	**Home Office Use Only**
☒ Benefit Enhancement Rider Units 2					

Cancer/Specified Disease (GVCP2) ☐ Yes ☐ No	Plan 1	☐ Employee Only ☐ Family	Section 125 ☒ Yes ☐ No	Total Premium $_____	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☒ Cancer Initial Diagnosis Option	☒ Cancer Screening	☒ Intensive Care Unit
Units	2	4	1	1	5	4	2

Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Premium $_____	**Home Office Use Only**
Basic Benefit Amount ☒ **$15,000**				
☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 4	☒ 2nd Event Initial Critical Illness Option		

Hospital Indemnity (GVSP1) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	Total Premium $_____	**Home Office Use Only**

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related
Units	2	1	1

ACCEPTANCE/AUTHORIZATION: I hereby request all coverage(s) 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 salary or wages, if applicable, the necessary premium for the coverages requested. **EFFECTIVE DATE:** 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 NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date Signed _____ **Employee's Signature** _____

Agent's (Producer's) Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Florida Agent (Producer) _____

Print Soliciting Agent (Producer) Name BeneCom Corporation/ Bradley J Shattuck

Florida Agent License Number Agency #R004515 Lic#A239806

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

Agent (Producer) Name	Agent (Producer) Number	National Agent (Producer) Number (NPN)	Percentage Credit
Servicing Agent (Producer): Benecom	4T1G0		0 %
Soliciting Agent (Producer): Benecom	4T1G0		90 %
Writing Agent: Amber Hoadley	801N0		10 %
			%

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ELECTRONIC DELIVERY ELECTION (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance (certificate(s)) and/or my policy(ies), including all documents accompanying my certificate(s) and/or my policies. I also elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) and/or my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will be mailed instructions at the last provided residence address and/or email address on how to receive my certificate(s), policy(ies) and correspondence at: www.allstatebenefits.com/mybenefits.

☐ Yes X No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 9.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that 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(s) and/or my policy(ies), 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.

I understand and agree that this election is effective for all certificate(s) and/or policy(ies) applied for and/or enrolled in on the date signed as noted below.

Proposed Insured Name: _____ Date Signed: _____

Owner Printed Name (if other than Insured): _____ Account Number (if applicable): _____

Owner Social Security Number: _____ Account Name (if applicable): _____

Owner Signature: _____